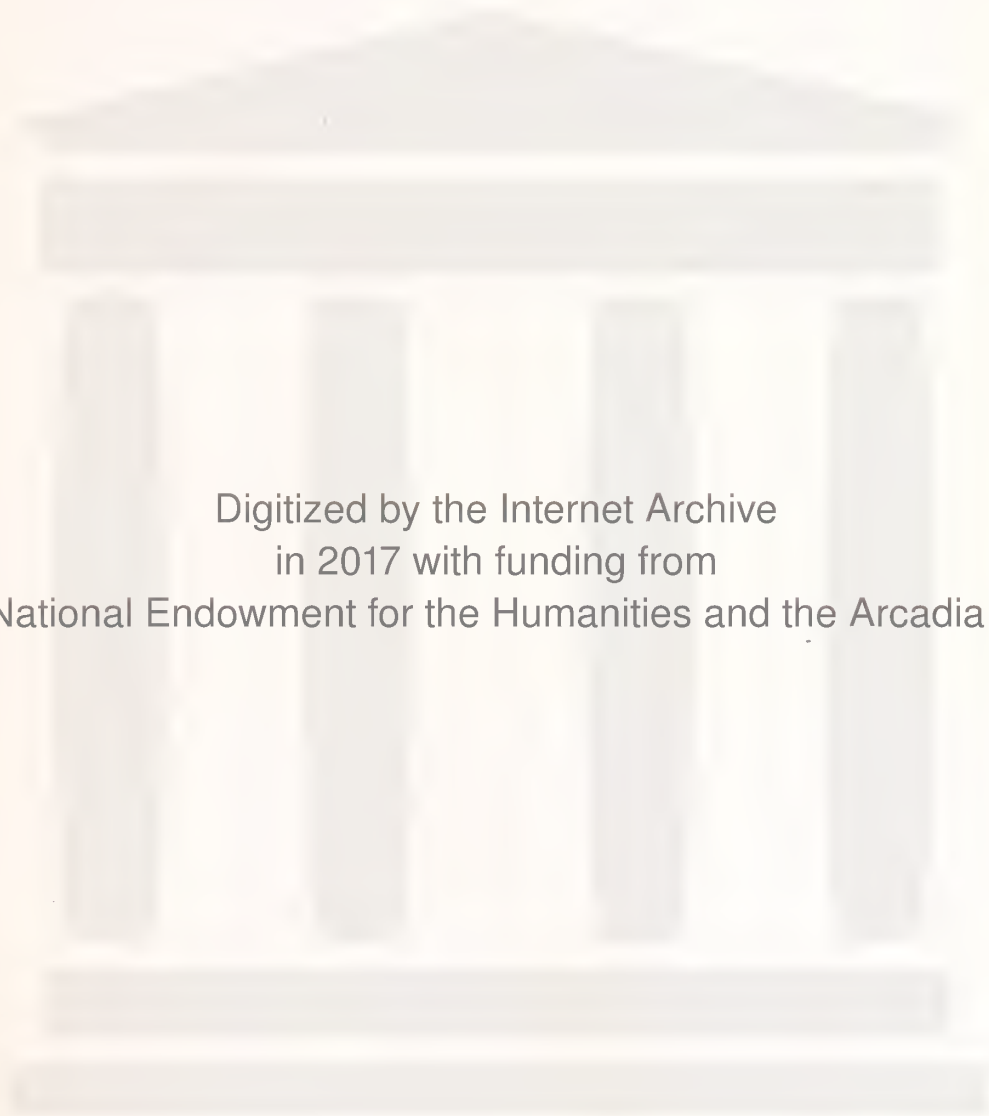
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SEPTEMBER-OCTOBER, 1961

Contents

Scientific Articles

Sarcoidosis in Hawaii ..... Donald W. Brown, M.D. 33
Contact Lenses ..... T. P. Frissell, M.D. 36
Puzzling Types of Abdominal Pain ..... Walter C. Alvarez, M.D. 38
Skin Diseases Affected by Pregnancy ..... Harry L. Arnold, Jr., M.D. 41
Hyperparathyroidism ..... G. B. Garis, M.D. 43

Editorials

Medical Discipline 52
National Foundation for Everything! 53
Nurses Support the King Bill 54

Features

Book Reviews 59
County Society Reports 62
Hawaii Medical Association 60
In Memoriam—Doctors of Hawaii—XXXIV 58
Notes and News 61
Poisoning 57
President's Page 49
This is What's New! 55

Inter-Island Nurses' Bulletin

General Interest 66
Book Reviews 71

Hawaii Technologists' Bulletin 72

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

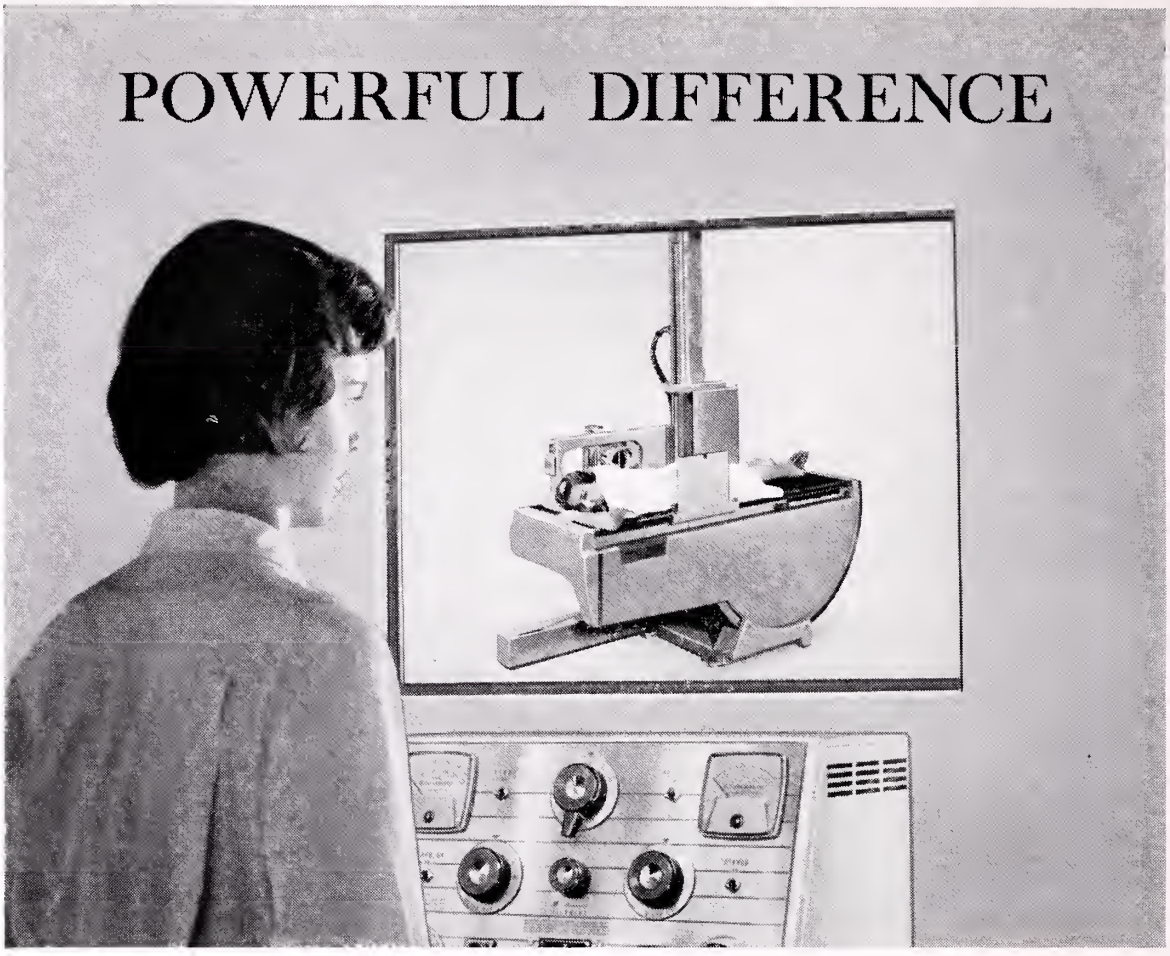
infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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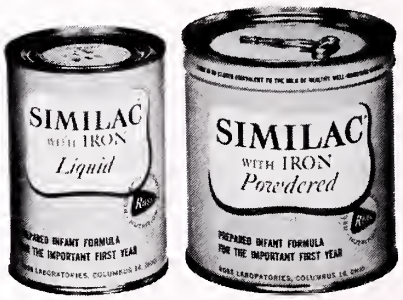
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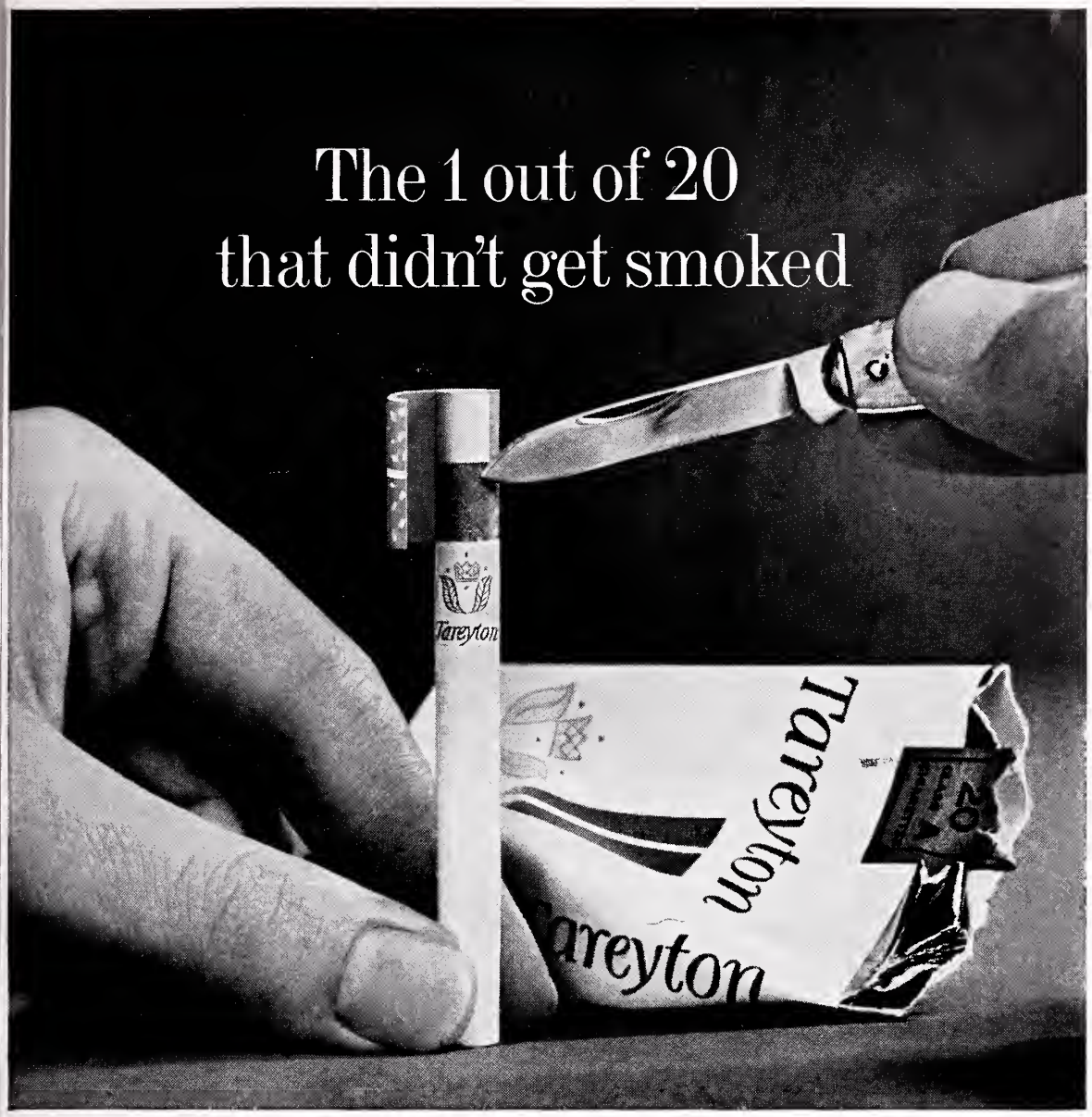
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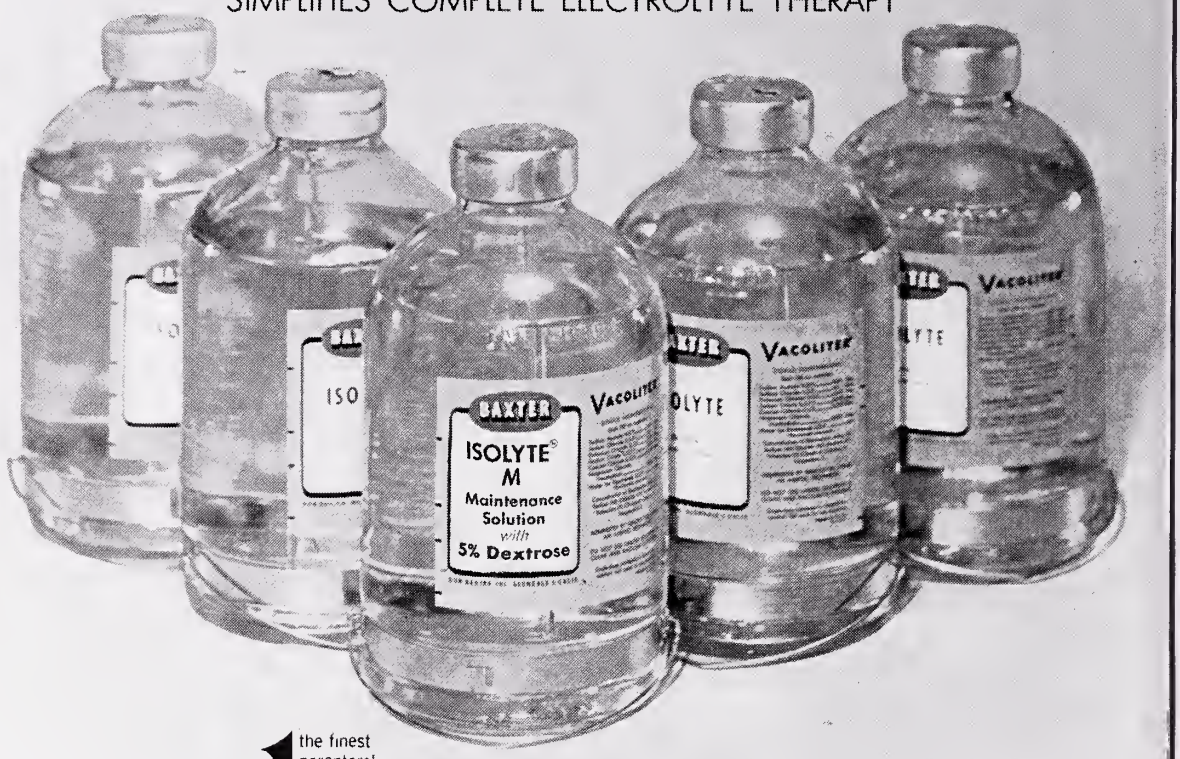
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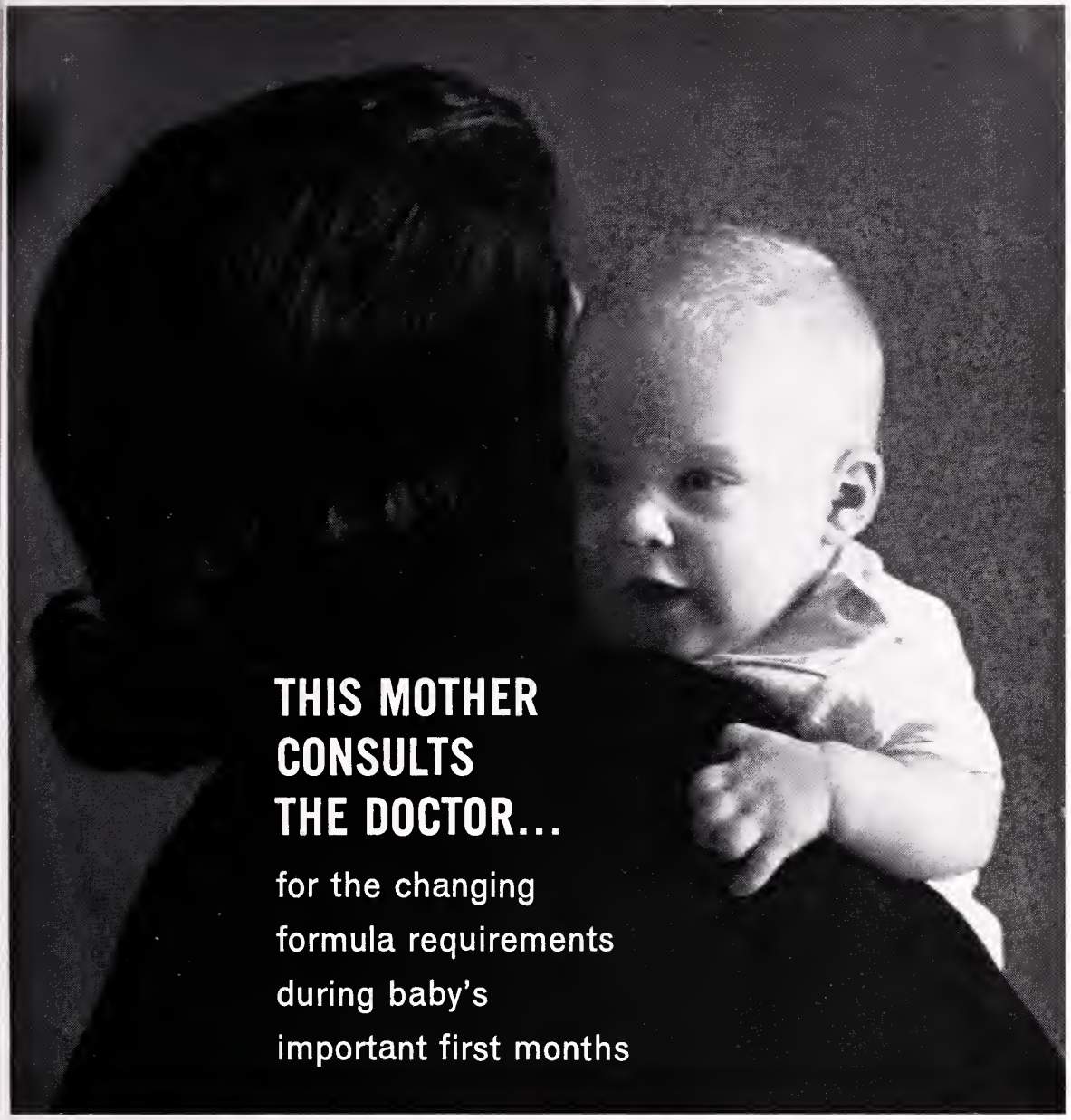
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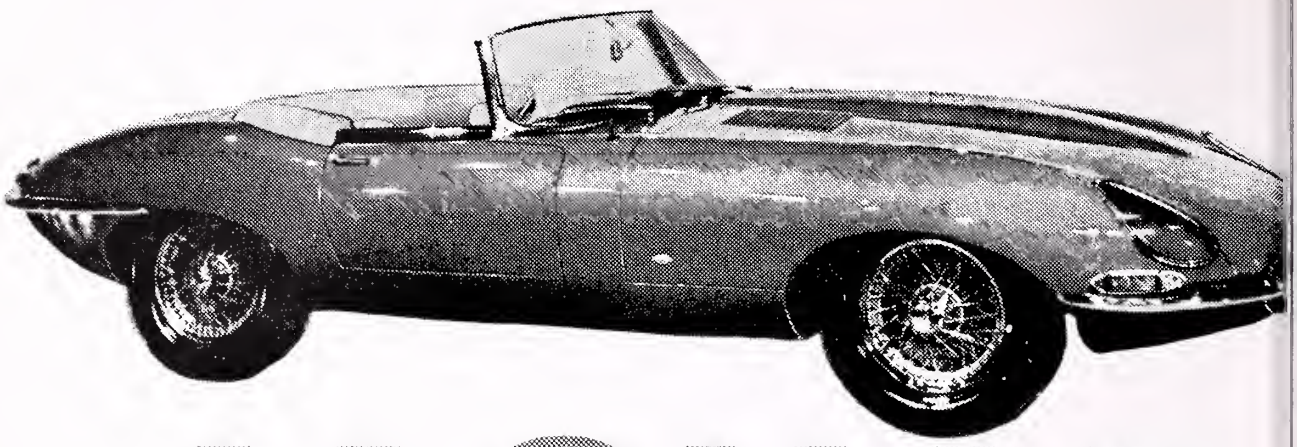
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We feel certain that this action, prompted by your comments and those of many other physicians, will simplify your writing of prescriptions for Terramycin products.

We welcome your comments on this action and on any other phase of our operations, since it is our objective to render every service as efficiently as possible to our friends in the medical profession.

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The following table indicates the former name and the current name of Terramycin systemic preparations:

FORMERLY NAMED	NOW NAMED
Cosa-Terramycin® Capsules	**Terramycin**® Capsules*
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Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

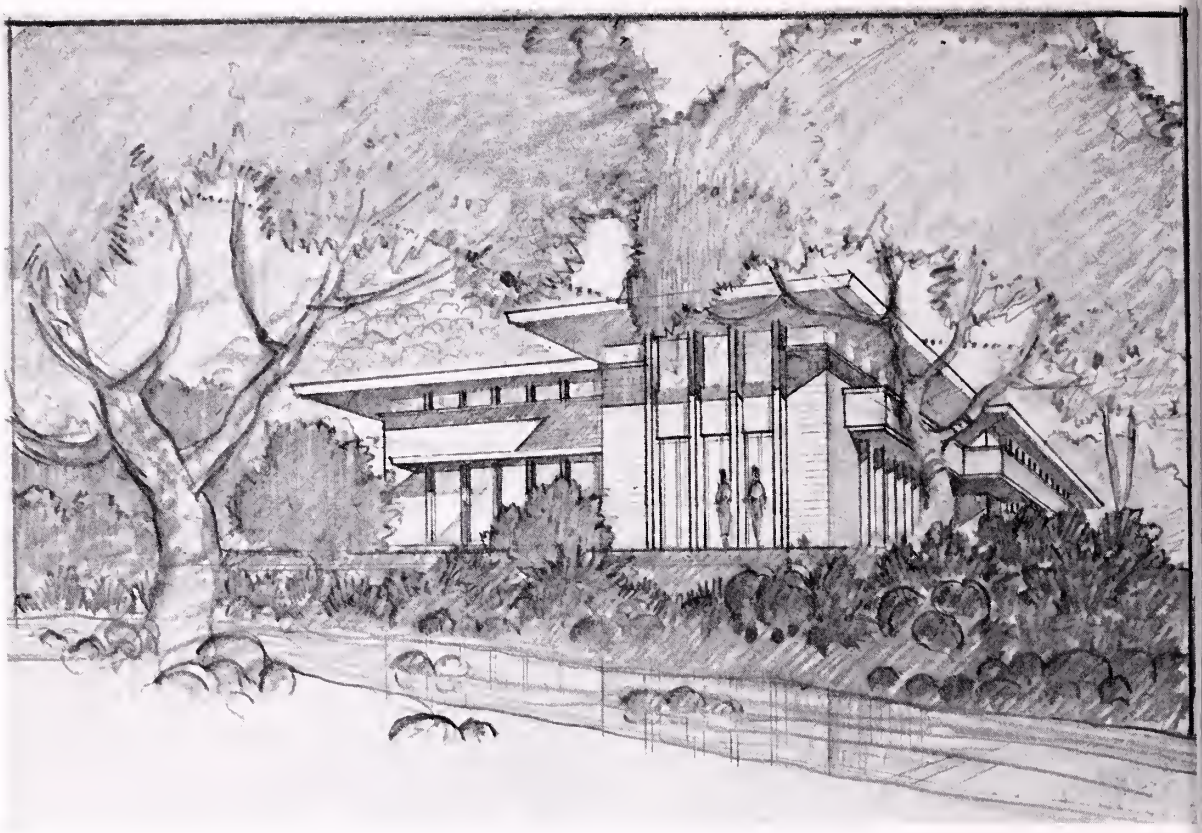
Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

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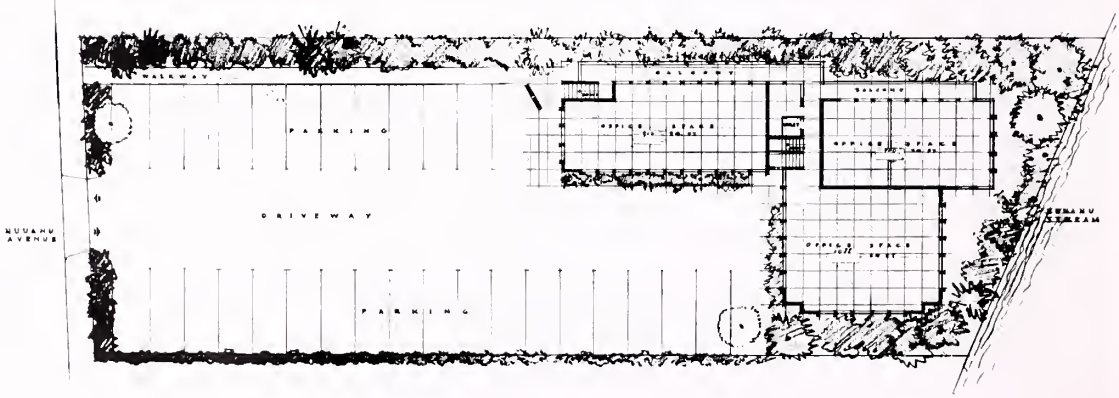
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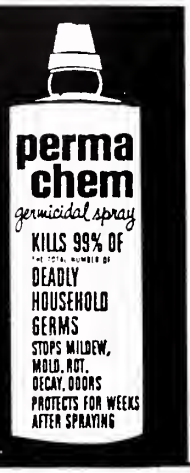
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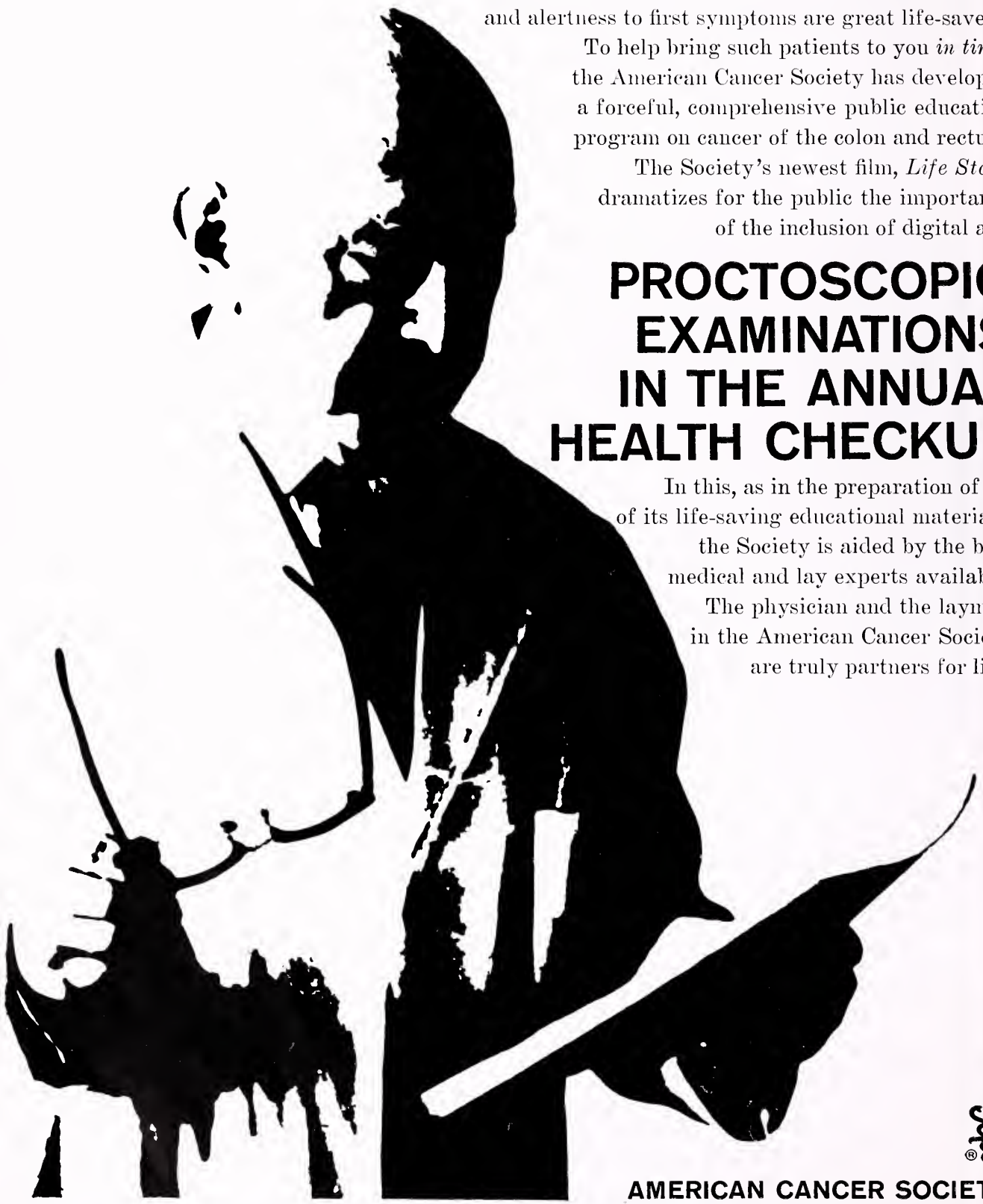
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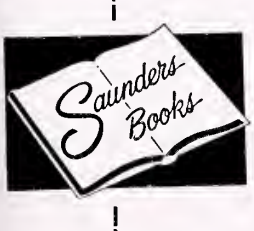
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*Gant, J. Q., Jr.: *M. Ann. District of Columbia 30*:267, 1961.

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Sarcoidosis, mysteriously, does not occur in Hawaii. Possible reasons are reviewed.

Sarcoidosis in Hawaii:

Why Doesn't It Occur?

DONALD W. BROWN, M.D., Honolulu

IN 1959, Harbinson[1] was not able to find a single documented case of sarcoidosis in an individual born in the State of Hawaii. The year before, Laing[2] found sarcoidosis to be a common disease in New Zealand. It seems likely that if we understood the reason for this difference in the incidence of the disease in these two island groups, which are in so many other respects similar, we would have in our hands the key to the etiology of this mysterious disease.



DR. BROWN Bauer

The prevalence of the disease in New Zealand has been confirmed by Mackay[3] and Reid and Gebbie.[4] It was felt worthwhile to undertake a more intensive search for cases in the Hawaiian Islands, in order to confirm Harbinson's work.

Results

On November 21, 1958, a folded postcard was sent to all the physicians in the State who were registered with the Hawaii Medical Association. On the detachable and returnable portion of the card it stated simply "I remember seeing a diagnosed case of sarcoidosis, Boeck's sarcoid, or sarcoid in the Territory of Hawaii." A space was left for the physician to mark "yes" or "no." He was then asked to sign his name.

Five hundred and ten of these postcards were mailed. By October 26, 1959, one year later, 303 had been returned. Of these, 275 physicians had answered "no." When the answer was "yes" the physician was contacted personally in order to obtain more details.

On further questioning, several of the positive answers were found to be erroneous. Several others were from physicians who had seen cases in consultation at Tripler Army Hospital. These cases will be mentioned below. One physician had a submaxillary lymph node removed from a teen-age boy with lepromatous leprosy because of its large size. The pathological diagnosis in this case was that it was a "sarcoid lesion." There was no other evidence of sarcoidosis in the case. Two physicians remembered seeing a patient in 1938 who had lived in Hawaii all his life and who had cutaneous sarcoidosis diagnosed by skin biopsy. His illness subsided spontaneously. Unfortunately, the pathological material and records from this patient are no longer available. Two women, recently moved from the mainland United States, have been treated in our State for sarcoidosis and these were both seen by a number of physicians thus accounting for the remaining seven of the positive answers.

All of the hospitals in the State of Hawaii were contacted and asked to make a search of their records as far as possible for proven cases of sarcoidosis. At the largest private hospital in the State, The Queen's Hospital, from January, 1948, to January, 1959, there were 154,306 admissions and only one case of sarcoidosis was signed out. This was a 24-year-old woman born in New York City and residing in Honolulu for fourteen months, who was treated in 1957 for sarcoidosis. A review of x-rays taken on the mainland before she came here, however, revealed the presence of similar lesions at that time.

Another large hospital, Kuakini, searched their records as far back as 1951, over a time in which all cases had been coded and no diagnosis of sar-

Presented at the Quarterly Regional Meeting of the American College of Physicians, Honolulu, Hawaii, November 3, 1960.

[1] Harbinson, J. A.: Sarcoidosis in Hawaii: Case report and discussion, Haw. Med. J. 18:496-500 (May-June) 1959.

[2] Laing, M. C.: Sarcoidosis: The incidence found by mass radiography, N. Zeal. Med. J. 57:593 (Dec.) 1958.

[3] Mackay, J. B.: Sarcoidosis: A report of 34 cases, Ibid. 581-588.

coidosis was made. One appendix was removed which showed "a sarcoid lesion" but there was no other evidence of the disease "sarcoidosis" in this patient.

Tripler U. S. Army Hospital serves as the veterans hospital for Hawaii and takes care of many local residents. From 1954 to 1957, they had 75,666 admissions. Sixteen patients were diagnosed as having sarcoidosis. All but three were active military personnel. One of these was a retired man from Los Angeles and the other two were servicemen's wives recently moved from the mainland. All of the active service personnel had been here only a short while.

Leahi Hospital is the tuberculosis sanatorium on Oahu. They had one case, a woman recently arrived from Louisiana.

Information available through the Bureau of Vital Statistics in the Department of Health was checked. Out of the 18,024 deaths from 1952 through 1957 (this did not include non-resident deaths) none was diagnosed as having sarcoidosis.

In summary then, an intensive effort was made to find a documented case of sarcoidosis occurring in a life-time or long-time resident of Hawaii, and none was found.

Discussion

The above study confirms Harbinson's belief that there is essentially no sarcoidosis in the natives of Hawaii. This is a striking difference when contrasted to the high incidence of sarcoidosis found in New Zealand. In order to evaluate the significance of this difference it is helpful to consider previously suggested causes of this disease.

Until very recently the most widely accepted belief was that sarcoidosis was caused by the tubercle bacillus.[5] Other suggested causes are: a bovine type or some other atypical acid-fast bacillus,[13] syphilis,[14] leprosy,[15] a virus,[18] silica (quartz),[21] beryllium,[24] grass or hay,[26] or a familial defect.[27] Many other agents have been suggested.[31]

More recently, wide interest has developed around the pine pollen theory of Cummings. Lamholt[32] first noted that sarcoidosis occurred principally in rural areas. In 1940, H. G. Whitehead[33] alluded to its occurrence principally in the temperate zones. In 1949, Ricker and Clark[34] found the birth places of a series of cases to be centered in the southeastern United States. The following year, Michael *et al.*[35]confirmed this finding, as did Welch.[36] In 1955, Gentry, Nitowsky, and Michael[37] carried this study further and suggested the incidence correlated well with certain "red-yellow Podzolic" (fine, sandy) soils.

Cummings and associates, however, studied 1,194 cases and suggested that significant numbers of these occurred in New England and the North Central States. He found that their distribution did not correlate closely with any particular soil but instead was closely related to certain forest distributions. They studied 100 communities. In 50, the incidence of sarcoidosis was high. In 50 it was low, and these served as control areas. In 40 of the 50 high-incidence areas, lumbering and milling were major industries. In only 22 of the 50 control communities were these major industries.[38]

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Meanwhile, investigators had been approaching the problem from a biochemical standpoint. In 1956, Nethercott and Strawbridge[42] felt that they had proved the previous existence of tuberculosis in sarcoid lesions by demonstrating the presence in them of alpha-epsilon diaminopimelic acid and mycolic acid, amino acids which occur in tubercle bacilli but not, normally, in the human body. Cummings,[43] however, was able to isolate the same chemicals from pine pollen. Further, he injected pine pollen and demonstrated it would produce an epithelioid response. He also noted that pine pollen was acid-fast. This was the origin of the suggestion that it was pine pollen specifically, and not just some vague relationship to pine forests, that caused sarcoidosis. The idea was carried further by Baer[44] who suggested the chewing of pine pitch which contains large quantities of pine pollen might have accounted for the occurrence of his four cases in twelve siblings. Richert, however, failed to develop sarcoidosis after the intentional oral ingestion of 720 mg of loblolly pine pollen over a thirty-day period.[45]

Considering the above information, we must conclude that the pine pollen theory is attractive but far from established.

Two recent reports which might have a very important bearing on the etiology of sarcoidosis are worthy of note. Hurley and Shelley[46] produced evidence which seems to rule out the "sarcoid diathesis" in which the sarcoid patient was felt to respond differently from a normal patient to a common stimulus. Lundbäck, Löfgren and Nordenstam[47] performed tissue culture experiments on sarcoid lesions which strongly suggested that sarcoidosis is not a neoplastic disorder, nor is it related to a virus. They found that a very interesting and characteristic patchy degeneration of outgrown fibroblasts frequently occurred. These changed fibroblasts demonstrated large eosinophilic inclusions. Further research centered about the nature of these inclusions may be very rewarding.

With all of these various etiologic suggestions in mind, then, let us consider New Zealand and Hawaii. Both are groups of islands located in the Pacific Ocean approximately 3,200 miles apart and about equidistant from the equator. The northern island of New Zealand is volcanic, as are all of the Hawaiian Islands, thus making it seem unlikely that some substance such as beryllium, peculiarly absent in volcanic soil, would account for the difference in the incidence of the disease in the two groups. The population of both islands is largely newly settled and in essence a mixture of a great many different peoples. This is particularly true in Hawaii. It seems highly unlikely that a collagen disease or a familial defect could strike one group of islands and not the other, in view of this. New cases of leprosy are uncommon in both island groups but there are still many old cases in Hawaii. Syphilis and gonorrhea are unusual in New Zealand but do occur there; they are much more common in the Hawaiian Islands. Virus infections are very common in Hawaii; in fact, although it cannot be documented, the physicians who practice here feel that virus infections are as common in Hawaii as in the rest of the United States.

The northern island of New Zealand is heavily forested with pine. There is very little pine forest in Hawaii. There is no significant amount of Norway pine in either island group. The Norway pine was introduced in New Zealand but it was almost all killed by insects. There are only four white pines in the Hawaiian Islands and these are on the island of Maui. In addition to natural forests in New Zealand there are 540,000 acres of radiata pine accounting for 59 per cent of the introduced timber; the remainder is 9 per cent ponderosa, 9 per cent Corsican, and 5 per cent Douglas fir. There are small numbers of other pine trees as well. In the Hawaiian Islands there are several thousand acres of Monterey pine on the island of Maui. There is also some loblolly, sugar, Ponderosa, and Mexican pine. In general, however, the trees are young and far from abundant.[48]

Summary

Attention has been called to the apparent absence of sarcoidosis in natives and long-time residents of Hawaii. At the same time it has been pointed out that sarcoidosis has a relatively high incidence in New Zealand. Previously suggested etiologies of this disease were noted and differences between New Zealand and Hawaii were considered in light of this.

No evidence for or against the pine pollen theory of Cummings could be produced, although New Zealand has considerably more pine forest, particularly on the North island, than Hawaii has. Because of its distribution in the two areas it seems unlikely that sarcoidosis could be caused by tuberculosis, leprosy, syphilis, a viral infection, a familial defect, or a soil factor.

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[43] Cummings.[41]
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1133 Punchbowl St.

Some patients cannot wear contact lenses, and some should not wear them. The story has two sides.

Contact Lenses

T. P. FRISSELL, M.D., Honolulu

CONTACT LENSES have been in existence for years, but it is only in the past five years that these have come into relatively general use; and this has produced new problems, medical and political, for the ophthalmologist.

Prescription contact lenses are either scleral or corneal in type. The scleral type are large, rest on the conjunctiva, and do not touch the cornea at all. They are generally quite uncomfortable to wear over a prolonged period of time. The type in vogue at the present time are corneal lenses. These are usually made of plastic, and average about 9.8 mm in diameter and 0.2 mm in thickness. These lenses "ride" on a thin layer of tears, and move back and forth over the corneal surface as the eyes move. The cornea thus is able to maintain close to normal nutrition and oxygenation. Also, it becomes obvious that lenses with grooves and windows will be of no benefit physiologically, though several types are marketed on this premise.

Use

An estimated six million people are wearing contacts full or part time; this is a ratio of about 1 to 12 as compared with spectacles. This makes the production and sale of contacts "big business", and their promotion is often on a similar business-like pattern. The advertising of some concerns is in my opinion quite misleading and their claims border on fraud.

Sources

Some practitioners grind their own lenses for the individual patient. The majority of dispensers obtain their lenses from a laboratory such as Obrig, where stock lenses of almost any power and curve are available. One major firm advertises that your prescription is kept constantly on file, so if you lose a lens, merely write and they will send a replacement from their nearest branch office. What happens to this patient if a mistake is made and the wrong lens sent to him; or if his corneal curvature has changed? There is no supervision whatsoever, and the potential for damage to the wearer's cornea is obvious.

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Indications and Risks

Who should wear contact lenses? Actually there are relatively few medical indications. Patients who have had a cataract operation on one or both eyes do well. The uniocular patient who has good vision in the unoperated eye is able to use the two eyes together comfortably, whereas with spectacles, he is unable to use the two eyes together because of the disparity of image size produced. Patients with high myopia often do better visually with contacts than with spectacles, and are able to obtain larger image size and some increase in visual field. Patients with some forms of corneal disorders, such as keratoconus, are often aided by contacts. Some people who have pitted and irregular corneas from disease or trauma do well. I have in mind a patient who had had trachoma which left the corneas faceted and the best corrected vision was 20/100. She corrected to 20/30 with contacts and was saved from having keratoplasty, which was being seriously considered.

There are definite hazards associated with the wearing of contacts. Patients with glaucoma, diabetes, chronic blepharoconjunctivitis, corneal dystrophies, or a history of herpes simplex of the cornea should not wear them at all. Among regular wearers of contact lenses, central corneal erosions often develop, frequently with apparently perfectly fitted lenses; and this I would presume is on the basis of partial anoxia. The cornea may gradually alter its shape, and the lens then rests on the apex. A lens which flattens the corneal apex will often produce edema and subsequent epithelial breakdown. Many patients are perfectly comfortable and unaware that these epithelial defects are present because the cornea has been rendered anesthetic by the lens. As an ophthalmologist, I become quite uncomfortable when I consider the potential for trouble in these constantly irritated epitheliums. It also presents an excellent argument for frequent checks by the patient to insure his corneas are intact.

Patients who sleep with their lenses in place often have a complete exfoliation of the epithelium from which they suffer excessive pain and require binocular dressings for several days until

ealed. Thus it behooves the anesthesiologist to make sure his patients are not wearing contact enses when being subjected to surgery. Some patients state they always have some discomfort wearing their lenses, but not enough to discontinue their use. These persons can be in serious rouble from a corneal ulcer or infection before eeking attention, because they were unable to ecognize anything out of the ordinary going on. One patient of mine had a groove worn into the nterior corneal stroma but delayed three days eeking attention because he had been seen two weeks before on a routine check. And, on the ther hand, a cornea rendered anesthetic by constant pressure can have serious disturbances present, though the patient is perfectly comfortable.

As stated above, there are some excellent medical reasons for prescribing contacts, but the vast majority are prescribed for cosmetic purposes only, and women users far outnumber men. Now, considering the potential hazards associated with the wearing of contact lenses—even perfectly fitted ones—should they be prescribed indiscriminately to anyone desiring them? I feel so strongly opposed to it that I refuse to prescribe for most of these cases, though I must admit that the majority of my colleagues are much less rigid in this respect.

Who Should Prescribe?

And conversely, who should be allowed to prescribe? This brings us to the most recent conflict between ophthalmologists and optometrists. Many optometrists do excellent work in fitting lenses, and in conversations some of those practicing in Hawaii admit that at least a third of their income is derived from this source. Opticians with proper training, on prescription from ophthalmologists, can also do excellent fitting.

The ophthalmologist, also with training, by himself can fit lenses and because of his medical training should do the best job and certainly is the most qualified. Most ophthalmologists in the press of a busy practice, however, prefer to refer the actual fitting to a qualified optician after proper examination, then check the lenses after the fitting.

The optometrists in many communities have attempted to legislate against opticians' doing fitting, on the basis that their training is not adequate or that supervision by the M.D. was not rigid enough. In some cases this is undeniably true, and here in the islands steps are being taken to rectify this problem. However, the deeper motivation is economic. If the opticians can be squeezed out, most ophthalmologists would still be too busy to handle the patients desiring contacts, and so they would go to the optometrist. To look further into this argument, we have those ophthalmologists who say that fitting is purely a medical problem and no one should be fitted except by an ophthalmologist or under his supervision. And to carry it one step further, though the optometrists "officially" objected to opticians inserting lenses, one of the major contact lens suppliers—owned by optometrists—has special courses to teach optometrists' office assistants in the inserting of patients' personal lenses. Just because they are under the same roof with the optometrist, are they more qualified to insert a lens than an optician?



DR. FRISSELL

Fortunately, here in Hawaii a member of the legislative committee of the Hawaii Medical Association meets regularly with a committee from the Optometric Society and representatives from the opticians' group to thrash out differences of opinion, air gripes, and attempt to work out equitable solutions to difficulties and maintain the integrity of each of the three fields.

Conclusion

In conclusion, then, contact lenses are here to stay, and are becoming more popular daily with the general public. They are not the innocuous accessories unscrupulous advertising would have us believe, and persons with certain disorders should never be allowed to wear them. It is possible for persons with apparently perfectly fitted lenses to get into trouble either from misadventure or from the cornea's changing its curvature. There are definite limited medical indications for their use. Theoretically, each patient who desires contact lenses should have a proper ophthalmological history and examination prior to fitting. In practice, the majority of contact lens users are fitted by optometrists and surprisingly few get into trouble. However small the percentage of contact wearers who do develop pathology, the potential for serious ocular trouble is so great that the prospective user should be made aware of the risks and impressed with the necessity of frequent follow-up checks on the health of his corneas.

1000 Ward Ave.

A master clinician warns us to remember that the central nervous system can produce abdominal pain.

Puzzling Types of Abdominal Pain

WALTER C. ALVAREZ, M.D., Chicago

WHAT DO you do when a patient with abdominal pain returns from the x-ray department and the laboratories with all the reports negative and no hint as to the cause of the disturbance? There is no sign of an ulcer or a gallstone or a cancer. For years, as a consultant in gastroenterology, I saw hundreds of these people. It was my job to try to make a definite diagnosis. How does one do it? I know of only one way, and that is to sit down and take a very careful and detailed history. Sometimes, one has to give the patient one half hour on each of several days, but at other times, in a few minutes, one can recognize a certain type of functional abdominal pain just as one recognizes the face of an old friend—because one has seen him so many times before.



DR. ALVAREZ

The Brain May Cause Abdominal Pain

The first thing we must face and we must keep remembering is the fact, which was not well hammered into us when we were students in medical school, that abdominal pain often arises in the brain. It can be due to organic disease in the brain or it can be due to mental distress, worry, anger, or indecision, or in many cases, to a psychosis or to epilepsy. It can be due to a little stroke, or an encephalitis, and commonly it is due to migraine.

How often a man will say, "My brother-in-law is a pain in the neck." He could just as well say, "He is a pain in the abdomen." For instance, recently, I saw a young woman who said she had a very troublesome epigastric pain. Able internists and roentgenologists had failed to find any local cause for it. In many of these cases, one can find the cause only by asking a relative. So I turned to the mother and said, "What is this due to?" She said, "It is due to a jaguar." This had me puzzled for a moment, but she went on to say that her son-in-law was a lovable chap but absolutely irresponsible and with no sense about finances. On his small salary, he would buy a motor boat or a German camera or a custom-built shotgun. Just before his wife's pain appeared, he came home with a 1956 Jaguar, delighted with it in spite of the fact that there was no money in the house to pay the rent or to buy food. The little wife wept and went to pieces nervously. That Jaguar was the last blow!

One of the best cases I know of to show how severe an abdominal pain can be when the cause is indecision is that of a powerfully-built professional athlete, a woman who, following her marriage a few years before, had suffered so much abdominal pain with fever that she had had four surgical explorations of her abdomen performed by excellent surgeons. On talking to a pal of hers, I discovered that the difficulty was that her husband was impotent with her and she could not make up her mind about a divorce. When I helped her to make the decision she craved, to leave her husband, she immediately became perfectly well. A year later, she had another spell of pain when she could not decide what to do about a new beau. When she left him, she again was well.

Some physicians may ask, "But can a lesion in the brain cause abdominal pain?" I will mention just two cases to show that it can. I will never

Extemporaneous address given before the Hawaii Medical Association, May 4, 1961.

Forget my shame years ago when I asked a surgeon to explore the abdomen of a girl of 12 who looked as if she had an acute appendicitis. She had nothing in her abdomen, and a week or two later it was obvious that she had a brain tumor. Another case that interested me much was that of a nice doctor of 60 who was suffering from severe pain in his epigastrium. Several internists had studied him carefully and no one could make a diagnosis. I suspected a carcinoma of the pancreas but could find no evidence to support this idea. Three weeks later, when he dropped dead, autopsy showed a perfectly normal abdomen. What he had was a tiny carcinoma of a bronchus with a large metastasis in his brain. I have seen many people with abdominal pain that came suddenly with what I call a little stroke, which badly injures the brain but does not produce either an aphasia or a hemiplegia.

I see any number of people with abdominal pain that is due purely to a psychosis. One day, I looked into our best book on manic-depressive psychosis to see what the early symptoms of that disease are, and I found that one of the commonest early symptoms is abdominal pain! I remember well a woman I saw a while ago who complained bitterly of only one thing and that was abdominal pain. I realized that she was at times weepy and depressed, but she maintained that if I suffered from pain as she did, I would be depressed, too. Finally, I had a psychiatrist give her a few shock treatments and the results were miraculous. She not only lost all of her depression but that same day she lost all of her abdominal pain.

Shortly before I left the Mayo Clinic, I pulled from my files the records of some 500 women with severe migraine. To my surprise, I found that a considerable percentage of them had complained mainly of pain or distress in the right upper quadrant of the abdomen. Because of this, many had submitted to a cholecystectomy, but in every case in which I had a follow-up record, the pain had come back.

Non-tabetic Gastric Crises

A while ago, I published some papers describing cases of what I call non-tabetic gastric crises. Such crises are commonly due to severe migraine; also, at times, to unrecognized mild epilepsy, and sometimes probably to an unrecognized psychosis.

The diagnosis in these cases is often easy if one will just ask and learn that the patient has previously had several or many similar attacks of pain and retching, all of which cleared up by themselves, usually in from 24 to 48 hours. The abdominal wall is unusually soft. There is no fever and the white blood count is low.

In cases of migraine, the diagnostic points are two: (1) that the spell begins with pain in or above one eye, and (2) at the start of a spell, the patient goes into an apathetic state or even a semi-coma. Helpful always is the story of typical "sick headaches" in the person's early years. If the patient has had many of these spells it is useless to explore the abdomen surgically. In one of my cases, the patient's abdomen has been explored 13 times and in another case it has been explored 9 times. Commonly today, I can make the diagnosis the minute I walk into the room and note the great apathy and depression of the patient.

Acute Abdominal Pain due to Epilepsy

I keep seeing people with a peculiar type of abdominal pain which is fairly obviously due to epilepsy, and often without the usual seizures. Often, in these cases, I get the story of epilepsy in the family, and often then I find an epileptic type of electroencephalogram in the patient.

A typical case is that of a young woman whom I saw recently. She came to me from a teacher of medicine who, on examining her from head to foot, and finding a soft cholesterol stone floating around in a normally functioning gallbladder, said that this must be the cause of her pain, and turned her over to a surgeon. The woman greatly angered her doctors by saying that she was sure they were wrong and that she was not going to be operated on. She said because her mother had had gallstone colic she knew that syndrome well, and she did not have it!

I asked her what her pain was like and she said that five or six times a day, she had a very frightening spell in which she felt as if an ice-pick was being driven into her abdomen. When I asked her to show me with her hand just where she felt the pain, she pointed to her supra-pubic region. Obviously, this could not be due to her gallstone. Because I had heard this peculiar ice-pick story many times before, I asked the woman if she had any epilepsy in her family. She said yes, her sister had a very severe form of epilepsy and she, the patient, had long suspected that what she had was a manifestation of the "family disease."

When I got electroencephalograms made, they showed the typical spikes and seizure discharges. And, as I remember, the giving of Dilantin put an end to the spells.

Features Which Suggest a "Functional Origin" of a Pain

There are a few features of abdominal pain or distress which suggest a cerebral origin. One is constancy, perhaps day and night over long pe-

riods of time; another is a complete lack of any relation to taking of food or drink or passing gas or feces; another is a burning element in the distress; another is the patient's statement that what he suffers is not really a pain; another is the fact that the distress comes in a wide area of the abdomen, and another is that it comes perhaps in the splenic area where pains of local organic nature are seldom felt; another is the fact that the distress sometimes goes down the outside of the thigh; another is the fact that when there are spells of distress, between them the person's digestion is perfect. This strongly suggests that there is no lesion in the digestive tube. Still another fact which should never be disregarded is that a mildly psychotic or hysterical type of person, who says he or she walks the floor each night with abdominal pain, has remained plump or even fat. Every time I have broken my rule and asked for a surgical exploration of the abdomen of such a person I have suffered much embarrassment. Nothing wrong was found.

Often, I find it very helpful in the diagnosis to ask and find that a somewhat peculiar or eccentric patient has some psychotic or alcoholic or epileptic relatives. In such cases it is good to get electroencephalograms made because sometimes the record is typically epileptic and then the giving of an anticonvulsive drug may work a cure.

In closing, I will refer briefly to a few types of functional abdominal pain.

Hysterical Bloating

A woman will bloat during the day—sometimes so much that she looks seven months pregnant. During the night the swelling goes down *without the passage of flatus*. It may disappear if the woman is put on her side on a table and the physician quickly pulls her knees up to her chin (Bargen's maneuver). One can always recognize the gasless type of bloating by getting an x-ray film made of the distended abdomen, and finding that there is no unusual amount of gas in the bowel. In these cases, the abdomen is pushed forward by a contraction of certain muscles. In most of these cases, there is little, if any, pain, but in a few cases the pain is so severe that the patient gets operated on several times, and sometimes ends up habituated to morphine.

Pain due to a "Little Stroke"

As I said before, sometimes a person past middle age will suddenly suffer an attack, perhaps with dizziness, wooziness, and rarely vomiting or diarrhea. With this, there seems to go a storm of some kind down the vagus nerves, a storm which often produces a pain or a feeling as if the bowel were being pulled in two. If this pain does not disappear within minutes it is likely to remain for months or years.

Arthritis in the Joint at the Lower End of the Sternum

Because of my interest in diseases of the stomach I have seen many persons, supposedly with an ulcer, whose pain and sensitiveness were localized in the joint at the lower end of the sternum where the xiphoid is attached. An arthritis in this joint can produce much local sensitivity and some pain. It is very easy to make the diagnosis just by pressing on the xiphoid process.

Thalamic Syndrome

In nearly all of the cases I have seen in which there was supposed to be some functional trouble with the upper end of the ureter, the patient had what is called a thalamic syndrome, due to some injury to the thalamus in the brain. This produces a remarkable hypersensitiveness of all of one side of the body. The diagnosis can be made so easily by asking if the patient has much hypersensitiveness of half of the face and scalp and of the foot, of the same side.

Porphyria

In the case of a highly nervous and at times slightly psychotic woman who has spells of abdominal pain, the physician ought to think of the possibility of porphyria. All he needs do is to test the urine for an excess of porphyrins. In these cases, one must never give sodium pentothal for an operation because this commonly causes the death of the patient. In acute spells, the urine turns red on exposure to sunlight. Sometimes, the skin of the arms is so sensitive to sunlight that after a day on the beach shallow ulcers form.

Spinal Nerve Injury or Fibrositis

Rarely, a pain in the abdomen is due to the collapse of the spine with pressure on nerve roots, or pain which follows the course of a spinal nerve is due to a cord tumor. Occasionally, abdominal pain is due to a fibrositis in the tissues of the anterior abdominal wall.

Summary

It has been pointed out that many abdominal pains are due to disturbances in the brain or in the spinal cord or in other parts of the nervous system. Hints are given for recognizing these types of pain.

700 No. Michigan Blvd.

Pregnancy helps most skin diseases somewhat.
It is the sole cause of just one: herpes gestationis.

Skin Diseases Affected by Pregnancy

HARRY L. ARNOLD, JR., M.D., Honolulu

THE MODIFICATION of skin diseases by pregnancy is seldom striking; generally, less skin trouble occurs during pregnancy than before or after it, with a few curious exceptions. Crawford found in nearly 50,000 case records at Boston Lying-In Hospital that well under one-half per cent of patients had had any skin disorder, as opposed to five per cent of patients in general practice and ten per cent of admissions to Massachusetts General Hospital, over the same 20-year period.[1]

Hollander and Vogel[2] classified skin disorders in pregnancy as either benefited, aggravated, or precipitated by the pregnancy. Not all diseases can be so neatly pigeonholed, but this arrangement does seem to provide a convenient and not illogical framework on which to hang a discussion.

Usually Benefited by Pregnancy

Pregnancy seems usually to have a beneficial effect on chronic acne, though occasionally the reverse effect is seen, and acne may occur late in the first trimester and continue until the early puerperium. The well-established tendency of acne to be alleviated by estrogenic hormone and aggravated by androgenic explains the beneficial effect neatly; "acne gravidarum" is a paradox.

Two diseases characterized by apocrine sweat gland obstruction—hidradenitis and Fox-Fordyce disease—are reported by Cornbleet[3] to have been relieved during pregnancy. Hidradenitis, however, is an intermittent disease anyway, and Fox-Fordyce disease is so rare that its alleviation by pregnancy is of largely academic interest.

Urticaria, like hay fever and asthma, may improve during pregnancy; it is tempting to suppose that the increased histamine-inactivating power of the blood of the pregnant woman has much to do with this. Psoriasis also improves with pregnancy as a general rule, however, and there is no basis for supposing that histamine inactivation has anything to do with this.

Systemic lupus erythematosus is seldom aggravated by pregnancy, though it may have its onset, or become worse, in the early puerperium. In acute cases, the risk of fetal death has been estimated by Ellis and Bereston[4] as about 30 per cent, and in subacute cases as 46 per cent, oddly enough. Cortisone therapy is not contraindicated during pregnancy. Interruption of pregnancy is not indicated in the great majority of cases. Mention should be made in passing of the possibility that systemic LE may be mistaken for toxemia of pregnancy. The blood pressure is typically normal in systemic LE. A negative test for the LE factor means exactly the same thing as no test: nothing at all.

Usually Aggravated by Pregnancy

The melanocytes of the skin "live it up" during pregnancy as a general rule; presumably this is largely because pituitary MSH (melanocytic-stimulating hormone) is increased, though progesterone and androgens also stimulate melanocytes. The skin darkens in many patients, especially in normally pigmented areas (genitalia, areolae, axillae, umbilicus, and linea alba). Localized patchy pigmentation of the cheeks, forehead, and neck (chloasma uterinum) commonly occurs, and seldom fades entirely after delivery. Enlargement or darkening of melanocytic nevi (moles), and appearance of new ones, may be seen. Neurofibromas, which are biologically lineal descendants of moles, may also enlarge. Malignant melanoma is aggravated, sometimes severely, by pregnancy, and may regress markedly afterward.

It has been mentioned that acne and psoriasis may begin, or get worse, during pregnancy; so may alopecia areata, and so may chronic atopic dermatitis (disseminated neurodermatitis).

Precipitated by Pregnancy

Chloasma ("liver spots"), striae distensae of the abdomen and hips, pedunculated skin tags of

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[1] Crawford, G. M., and Leeper, R. W.: Diseases of the skin in pregnancy, Arch. Dermat. & Syph. 61:753 (May) 1950.

[2] Hollander, L., and Vogel, H. R.: Notes concerning some of the more frequent skin diseases occurring during pregnancy, 00000

[3] Cornbleet, T.: Pregnancy and apocrine gland disease: hidradenitis, Fox-Fordyce disease, A.M.A. Arch. Dermat. & Syph. 65:12 (Jan.) 1952.

[4] Ellis, F. H., and Bereston, L. S.: Lupus erythematosus associated with pregnancy and menopause, A.M.A. Arch. Dermat. & Syph. 65: 170 (Feb.) 1952.

the breasts and neck, and gingival congestion and hypertrophy, usually mild, rarely severe, are familiar to all obstetricians—so familiar, indeed, that except for persistent chloasma they are seldom seen by dermatologists.

"Vascular spiders"—which until William Bean put them on the medical map[5] had gone by such names as nevus araneus (spider nevus: poor names, since the lesion is not genetic) or stellate angioma—occurred in two-thirds of nearly 400 pregnant white women and over 11 per cent of 759 Negro women in Bean's series. Ninety per cent of blondes and 60 per cent of brunettes had some spiders. They are usually accompanied by some degree of palmar erythema, though either may occur independently. They usually disappear after delivery; in two months only one-fourth of them are left. The spiders seldom get as large or numerous, or the palmar redness as intense, as in patients with hepatic cirrhosis (which of course lasts somewhat longer than pregnancy), but otherwise there is nothing to distinguish between the two causes. Bean suggests that high blood estrogen levels may cause them. If they fail to disappear after delivery—as one in four or five is apt to do—they can be obliterated neatly by electrodesiccation of the central arteriole.

Pruritus vulvae—due to moniliasis, Trichomonas infection, varicosities, or neurodermatitis—may apparently be precipitated by pregnancy but it is not in my experience a common complication.

Urticaria may infrequently complicate pregnancy, especially during the sixth month, when lesions may begin in the abdominal striae. It is not apt to be persistent or severe.

Prurigo gestationis, a generalized eruption of intensely itchy small papules, chiefly on the extensor surfaces of the extremities, has been described again and again in textbooks and articles; I have never observed it.

Impetigo herpetiformis, about which much is copied,[6] seems to have vanished from the clinical scene. Since it was often fatal, this is just fine. I have never seen a case.

Herpes Gestationis

There is fairly general agreement that only one disease, herpes gestationis, is peculiar to pregnancy—yet, oddly enough, it cannot be sharply distinguished on any basis from dermatitis herpetiformis, to which men are more prone than women. Since the latter qualifies pretty well as one of the many diseases which can result from multiple causes, it seems possible that pregnancy itself merely provides one more possible cause. At all events, the disorder may begin between the third and the fifth month (usually later rather than earlier) and clears promptly on termination of pregnancy.

The diagnostic signs are the same as for dermatitis herpetiformis: intense itching, grouping, symmetry, eosinophilia (blood or tissue or both), iodide sensitivity, subepidermal vesicles or less often bullae, residual hyperpigmentation, and scars, and responsiveness to sulfonamides (especially sulfapyridine) or sulfones, orally. Only spontaneous remissions, among the cardinal diagnostic signs of "d.h.," are lacking.

I have, in one instance, seen a severe recurrence precipitated early in the postpartum period by administration of stilbestrol for the purpose of suppressing lactation.

There appears to be no direct relationship between herpes gestationis and either the sex of the fetus, or the presence of toxemia.[7] Toxemia was found by Crawford[1] in about 15 per cent of all his cases of skin disease seen during pregnancy, as opposed to a national average of 8 per cent of pregnant women. As he pointed out, however, the small size of his series made any interpretation of the figures unreliable.

The management of herpes gestationis is apt to be difficult; sulfapyridine or Azulfidine (salicylazosulfapyridine) should be tried, or sulfones (Avlosulfon, Diasone, Promacetin, etc.) if they fail or are not tolerated. If sulfones fail, cortisone (Medrol [methyl prednisolone] triamcinolone, or prednisone or prednisolone) is indicated. Rarely, today, should interruption of pregnancy be required for control of this disorder.

Summary

During pregnancy pigmentation is on the increase and vasodilatation (in the vagina, mouth, and skin) is often conspicuous and sometimes spectacular. The same "vascular spiders" and palmar erythema that are characteristic of hepatic cirrhosis occur in some degree during pregnancy in most blondes and many brunettes.

Most skin disorders are seen somewhat less often in pregnant women than in other patients.

Herpes gestationis—dermatitis herpetiformis directly attributable to the gravid state—is the only dermatosis generally regarded as peculiar to pregnancy.

Knowledge of this entire field is incomplete and vague, and more carefully recorded data would be of great value in clarifying the relationships between dermatoses and pregnancy.

[5] Bean, W. B., Cogswell, R., Dexter, M., and Embrick, T. F.: Vascular changes of the skin in pregnancy. Vascular spiders and palmar erythema, Surg., Gynec. & Obst. 88:739 (June) 1949.

[6] Pastras, T., Beerman, H., and Jumbala, P.: Dermatoses of pregnancy: a review of some of the recent literature, Am. J. Med. Sci. 236:507 (Oct.) 1958.

[7] Costello, M.: Eruptions of pregnancy, N. Y. State J. Med. 41:849 (Apr. 15) 1941.

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Even thinking of hyperparathyroidism and checking the blood calcium and phosphorus won't find all cases of it. Still, it's worth a try.

Hyperparathyroidism

G. B. GARIS, M.D., Honolulu

ALTHOUGH we are finding many solitary thyroid adenomas, perhaps we are not recognizing the parathyroid adenoma and hyperparathyroidism as often as it is being reported from other medical centers. If this is true, several possible explanations come to mind. We are all familiar with the variance in incidence of many diseases in the various racial groups in Hawaii. In reviewing the literature, mention of a racial variance in the incidence of hyperparathyroidism was not encountered. However, there is the possibility, which should be investigated, that a racial variance in incidence of hyperparathyroidism might account for a low incidence of hyperparathyroidism in Hawaii, if such exists. On the other hand, we are no doubt overlooking an occasional case.



DR. GARIS

Hyperparathyroidism is often a chemical rather than a clinical diagnosis. Since the abnormal chemical findings of hyperparathyroidism may occur only intermittently, and there may be only minor deviations from normal, the need for repeated and accurate laboratory studies in suspected cases has been stressed often. I suspect that if we search diligently for hyperparathyroidism, with a high index of suspicion for the possibility of the disease, we will find in Hawaii, as other medical centers have found in other localities, that hyperparathyroidism is much less rare than it now seems.

Early Diagnosis

So protean are the manifestations of hyperparathyroidism that Goldzieher[1] has suggested that it replace syphilis as "the great imitator." The varied symptomatology of this complex metabolic disease makes the diagnosis difficult in the early stages of the disease. Yet, the prognosis of the patient with hyperparathyroidism is dependent on the status of the renal function at the time of surgery. For this reason, it is important to recognize the disease as early as possible, before permanent renal impairment develops.

Duration of Symptoms

In Hellstrom's[2] series of 50 cases, the average duration of symptoms was eight years, with 11 patients having symptoms for more than 15 years; four patients for over 20 years; and one patient with symptoms for 31 years.

In the series of Bogdonoff *et al.*,[3] the average duration of symptoms was 12 years, the range being from 1½ to 28 years. Mention is made of other cases reported in the literature of 39 years', 32 years' and 27 years' duration. They point out that extremely long histories are a point in the favor of the diagnosis of hyperparathyroidism, which is, except for an occasional case of acute parathyrotoxicosis, essentially a chronic illness.

Symptoms Referable to Bone Disease

The amount of bone involvement in hyperparathyroidism is related to the level of calcium intake rather than to the duration or the severity of the parathyroid disease. Due to the usual high intake of calcium and phosphorus in the American diet, skeletal involvement in hyperparathyroidism is often entirely absent or insignificant.

In our search for hyperparathyroidism, I do not anticipate finding many cases of hyperparathyroidism with symptoms referable to bone disease. However, patients with symptoms of bone or joint pain or diffuse bone disease should be investigated.

[1] Goldzieher, J. W.: New techniques in the diagnosis of hyperparathyroidism, Geriatrics 13:483 (Aug.) 1958.

[2] Hellstrom, J.: Primary hyperparathyroidism; observations in a series of 50 cases, Acta. Endocrinol. 16:30 (May) 1954.

[3] Bogdonoff, M. D., Woods, A. H., White, J. E., and Engel, F. L.: Hyperparathyroidism, Am. J. Med. 21:583 (Oct.) 1956.

The pain may be excruciating and associated with marked tenderness. Giant cell tumors, insidious fractures, deep-aching backache, postural changes, kyphosis, scoliosis, deformities especially in the legs, pelvis, vertebrae, and thorax, and patients with gait abnormalities should be screened for hyperparathyroidism. The tumors and cysts are especially common in the maxilla, mandible, pelvis, end of long bones, metatarsals, and metacarpals. Due to demineralization, the bones of the jaw may become so soft that the teeth may fall out. Also, patients with bone disease resulting from hyperparathyroidism may have anemia and leukopenia resulting from fibrosis of the bone marrow.

Markham[4] has pointed out that numerous conditions may be associated with obscure primary hyperparathyroidism. He points out that osteoarthritis, especially of the spine, and osteoporosis are frequently associated with hyperparathyroidism, the other symptoms of hyperparathyroidism being attributed to the arthritis or osteoporosis. He recommends screening patients with osteoarthritis and osteoporosis for hyperparathyroidism.

Symptoms Referable to the Urinary Tract

Polyuria, polydipsia, nocturia, enuresis, frequency, renal colic, hematuria, and passing sand are symptoms that may be encountered in hyperparathyroidism with urinary tract disease. Heyman[5] states that in many series, it has been shown that 70 to 85 per cent of cases of hyperparathyroidism present with renal lithiasis and the incidence of hyperparathyroidism in stone patients has been reported in the literature as being from 1 to 15 per cent, more practically from 4 to 8 per cent. I am sure we are not finding hyperthyroidism in this incidence in our patients with renal lithiasis and I believe we should intensify our search for hyperparathyroidism in this group of patients.

Beard and Goodman[6] found that in two-thirds of their cases of hyperparathyroidism only a single stone had formed, and emphasized the fact that hyperparathyroidism should be looked for in all cases of renal lithiasis, not only in cases of recurrent or multiple lithiasis. Stones may form in either kidneys or bladder. Staghorn calculi are unusual but may occur. Renal calcinosis severe enough to be evident roentgenologically is less common than lithiasis and is invariably associated with impairment of renal function. Renal failure with or without secondary anemia and hypertension, sometimes associated with severe headache, is the late result of renal damage in this disease.

[4] Markham, J. D.: Protean manifestations of primary hyperparathyroidism, Virginia Med. Monthly 84:563 (Nov.) 1957.
[5] Heyman, A. M., and Lombardo, L. J., Jr.: The urologist's role in the diagnosis of hyperparathyroidism, J. Urol. 83:727 (May) 1960.
[6] Beard, D. E., and Goodman, W. E.: Hyperparathyroidism and urolithiasis, J. Urol. 64:638 (Nov.) 1950.

Symptoms Referable to the Gastrointestinal Tract

Gastrointestinal symptoms are often a major feature in the history of a patient with hyperparathyroidism. Symptoms which may be related to hypercalcemia include anorexia, nausea, vomiting, weight loss, abdominal pain, and constipation. Also, ulcer-like distress or dyspepsia is often a prominent symptom. Other symptoms include belching, gaseous distention, difficulty in swallowing, polydipsia, heartburn, and flatus. Peptic ulcer is thought to be eleven times more common in patients with hyperparathyroidism than in the general population.[7]

In the series of Black,[8] 24 per cent of patients with proved hyperparathyroidism had at the time of examination, or had had in the past, objective evidence of peptic ulcer or had had operations on the stomach presumably because of ulcers. An additional 15 to 20 per cent of the patients had had some ulcer-like symptoms but an ulcer had never been proved.

Kirsner[9] mentions other series of cases of hyperparathyroidism with similar high incidence of peptic ulcers. In the ulcer patient with hyperparathyroidism, accentuation of ulcer symptoms may occur with conventional ulcer therapy, or the patient may state that milk does not agree with him, or that milk does not relieve the abdominal pain, or that although milk relieves the abdominal pain he feels worse after a while[3,10]. Also, anorexia, nausea, or vomiting in an uncomplicated ulcer case without impaired gastric emptying may be an additional clue to the possibility of hyperparathyroidism. An ulcer intractable to ordinary medical or surgical treatment or recurrence of ulcer at diverse sites in the gastrointestinal tract should arouse suspicion of hyperparathyroidism.

Frame and Haubrick[10] screened 300 consecutive patients with the clinical diagnosis of peptic ulcer (251 duodenal ulcers and 49 gastric ulcers) and found four cases (1.3 per cent) of hyperparathyroidism. In addition to duodenal and gastric ulcers, jejunal and esophageal ulcers have also been reported in hyperparathyroidism. Medical treatment of peptic ulcers complicating hyperparathyroidism has the inherent danger of precipitating acute parathyrotoxicosis and of calcium salt deposition in the urinary tract.

An increasing number of cases are being reported in the literature of acute pancreatitis as a complication of hyperparathyroidism, such as the

[7] Jarvis, F. J., Sanderson, E. R., and Coe, R. C.: Hyperparathyroidism—a review of a community experience in Seattle hospitals, Am. J. Surg. 94:292 (Aug.) 1957.
[8] Black, H. M.: Hyperparathyroidism, American Lecture Series, Springfield, Ill., 1953, Charles C. Thomas.
[9] Kirsner, J. B.: The parathyroid and peptic ulcer, Gastro-Enterol. 34:145 (Jan.) 1958.
[10] Frame, B., and Haubrich, W. S.: Peptic ulcer and hyperparathyroidism, a survey of 300 ulcer patients, Arch. Int. Med. 105:536 (Apr.) 1960.

case reported by Hoar and Gorlin.[11] They raised the question as to whether unsuspected cases of pancreatitis account for many of the case of abdominal pain in patients with hyperparathyroidism. Jackson[12] reported six or possibly seven cases of hereditary hyperparathyroidism in two generations of one family associated with recurrent pancreatitis in at least two instances. Hereditary hyperparathyroidism has also been reported in association with peptic ulcers.

Hyperparathyroidism has been reported to be associated with chronic calcific pancreatitis. Coffey *et al.*[13] have reviewed reported cases and presented one case of their own. It is believed that the number of reported cases may represent only a small fraction of actual cases. They point out that the findings of calcification in various sites throughout the body in association with calcific pancreatitis has been noted. The more common sites are the prostate, genitourinary tract, conjunctiva, and liver. They point out that a depression of the serum calcium not infrequently accompanies acute pancreatitis or an acute exacerbation of chronic pancreatitis and a normal serum calcium level may provide false evidence concerning both hyperparathyroidism and the hypocalcemia of pancreatitis. Gallstones are found with greater frequency in patients with hyperparathyroidism than in patients at large.[14] It is in this category of patients with gastrointestinal symptoms, in addition to those with urinary tract symptoms, that I am hopeful of finding cases of unsuspected hyperparathyroidism. It is in this group that one is most apt to find hyperparathyroidism before irreversible kidney damage, renal insufficiency, or hypertension has taken place.

Symptoms Referable to the Cardiovascular System

Bradycardia and cardiac irregularities may occur in hyperparathythroidism, and angina has been reported to be a complication of it. Peripheral vascular insufficiency due to arterial calcification may be a prominent manifestation of hyperparathyroidism. Thus, pulselessness of an extremity, pallor, cyanosis, cold feet, intermittent claudication, ulcers of the leg, and gangrene may be manifestations of hyperparathyroidism in certain patients.[3]

Symptoms Referable to the Central Nervous System and Neuromuscular System

Mental changes including psychosis and hallucinations have been reported in hyperparathyroidism.[15] Disturbed mental function, mental retardation, and marked behavior alterations may occur. Other symptoms mentioned in hyperparathyroidism include irritability, unconscious spells, insomnia, depression, disorientation, confusion, apathy, occipital headaches, contrariness, maliciousness, delusions, drowsiness, personality changes, memory loss, amnesia, tingling, twitching, and paresthesias of the hands or feet. Unequal reflexes, Babinsky's sign, and hyperreflexia have been reported. Dramatic mental manifestations may include stupor, convulsions, and coma. Lethargy, lassitude, muscular weakness, listlessness, easy fatiguability, muscular aches and tenderness, and spasticity are neuromuscular symptoms seen in hyperparathyroidism. Low backache and inability to carry out the duties of daily living are often prominent symptoms. Often a combination of these symptoms results in the patient being classified as a neurotic or neurasthenic. Murphy *et al.*[16] reported a case in which striking muscular weakness was the major complaint of a patient with a parathyroid adenoma. Edwards and Daum[17] reported cases of increased spinal fluid protein in hyperparathyroidism and other hypercalcemic states and draw attention to the possibility that elevation of the cerebrospinal fluid protein can occasionally be a feature of the hypercalcemic state without evidence of organic brain disease.

Obstetrical Considerations

Hyperparathyroidism interferes with normal gestation. Delayed onset of labor is seen. Mothers of babies who have severe tetany should be investigated for hyperparathyroidism. McGeown and Field[18] reported a case of hyperparathyroidism which was asymptomatic and discovered by investigation of a mother who was completely free of symptoms, but whose baby had tetany.

Symptoms Referable to Other Systems

Decreased auditory acuity, dryness of the nose and mouth, difficulty in focusing the eyes, band keratitis, eye pain, blindness, diplopia, injection of the sclera, and photophobia may be manifestations or hyperparathyroidism of special interest to the ophthalmologist and otolaryngologist. Burning of the skin and dehydration have also been reported in the symptomatology of hyperparathyroidism.

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[11] Hoar, C. S., Jr., and Gorlin, R.: Hyperparathyroidism and acute pancreatitis, New Eng. J. Med. 258:1052 (May) 1958.

[12] Jackson, C. E.: Hereditary hyperparathyroidism associated with recurrent pancreatitis, Ann. Int. Med. 49:829 (Oct.) 1958.

[13] Coffey, R. J., Canary, J. J., and Dumais, C. C.: Hyperparathyroidism and chronic calcific pancreatitis, Am. J. Surg. 25:310 (May) 1959.

[14] Cope, O.: Hyperparathyroidism: diagnosis and management, Am. J. Surg. 99:394 (Apr.) 1960.

[15] Agsa, J. W., and Goldsmith, R.: Primary hyperparathyroidism with peptic ulcer, a report of two cases, Ann. Int. Med. 48:163 (Jan.) 1958.

[16] Murphy, T. R., DeMine, W. H., and Burbank, M.: Hyperparathyroidism: report of a case in which parathyroid adenoma presented primarily with profound muscular weakness, Proc. Staff Meet. Mayo Clinic 33:629 (Nov.) 1958.

[17] Edwards, G. A., and Daum, S. M.: Increased spinal fluid protein in hyperparathyroidism and other hypercalcemic states, Arch. Int. Med. 104:29 (July) 1959.

[18] McGeown, M. G., and Field, C. M. B.: Asymptomatic hyperparathyroidism, Lancet 2:1268 (Dec.) 1960.

Multiple System Involvement

Any organ system or any combination of organ systems may be the sites of involvement in patients with hyperparathyroidism. When several body systems are simultaneously disturbed in hyperparathyroidism, the clinical picture may be confused with clinical entities more frequently associated with multiple system involvement, such as one of the collagen diseases. Bogdonoff[3] reported such a case in which the patient was thought to have lupus erythematosus and the downhill course was thought to be due to renal involvement by lupus erythematosus. However, at autopsy the pathologic findings were unequivocally characteristic of hyperparathyroidism.

Acute Hyperparathyroidism

The syndrome of acute hyperparathyroidism is rare. Symptoms include vomiting, lethargy, and progressive azotemia leading to coma which may terminate in death.[19] The serum calcium may rise so high (17 to 20 mg per cent) that metastatic calcification and chemical death occur. The critical level of calcium seems to be about 17 mg per cent. Acute hyperparathyroidism may be precipitated by a period of relative immobilization, such as hospitalization for diagnostic studies. In any case of hyperparathyroidism, particularly in cases in which the serum calcium is unusually high and associated with some impairment of renal function, dehydration may initiate acute hyperparathyroidism. This is another reason why hyperparathyroidism should be excluded before operations for renal lithiasis or ulcer are undertaken. Acute hyperparathyroidism may also be initiated by the injudicious treatment of a demineralization of the skeleton, or an ulcer, with calcium, milk, or vitamin D. Any agent which could increase the level of calcium or phosphorus is contraindicated in hyperparathyroidism.

Physical Diagnosis

The findings on physical examination, as with the symptomatology, vary according to the body system or systems involved. Abnormal physical findings are notoriously lacking in hyperparathyroidism and physical examination is usually not helpful in its diagnosis. Markham[4] reported six cases, in which three had palpable thyroid masses. He has stressed that thyroid enlargement, particularly nodular or unilobar masses, should be regarded with suspicion as a parathyroid adenoma may be buried in the thyroid and thyroid disease may or may not be present as well. All patients with thyroid masses should have complete laboratory work-up for parathyroid disease. However, this is an infrequent finding in most series. Randall and Keating[20] in discussing serendipity in primary hyperthyroidism reported three cases in which hyperparathyroidism was discovered accidentally during operations for disorders of the thyroid, and one case during the removal of a pharyngo-esophageal diverticulum. In one of the cases, there were no symptoms or complications attributable to hyperparathyroidism, which was therefore regarded as asymptomatic.

Roentgen Diagnosis

The roentgenological findings are varied, and as with the symptomatology, one or more body systems may be involved. Bone lesions in x-rays may vary from none, through some demineralization of the skeleton, to osteitis fibrosa cystica of von Recklinghausen with generalized decalcification of the skeleton and numerous cystic lesions, sometimes associated with deformities. The phalanges are often early sites of small cystic changes and cortical thickening. The metacarpals, metatarsals, and ends of long bones are also often sites of bone cysts. The maxilla and mandible are often the first sites of cystic changes. There may be wedging of the vertebral bodies, and a generalized ground-glass appearance of the skull may be seen. "Pathologic" fractures may be demonstrated roentgenologically and many types of deformities, such as bending of the long bones, or various deformities of the pelvis and vertebrae, may be found. Absence of the lamina dura around the teeth may be demonstrated in certain cases. No calcium is lost from the teeth in hyperparathyroidism and the teeth may appear abnormally dense in contrast to the surrounding bones which may have some decalcification.

Roentgenographic evidence of renal system involvement is in the demonstration of renal calculi or nephrocalcinosis. Except for the kidneys, calcification of the soft tissue is usually not apparent roentgenographically. Infrequently, a barium swallow may reveal an extrinsic deformity of the cervical esophagus due to pressure from a large parathyroid adenoma. Intra-articular and periarticular deposits of calcium may rarely be found in hyperparathyroidism. In those cases with peptic ulcer, the ulcer may be demonstrated on roentgenologic examination of the upper gastrointestinal tract. Angiography has been useful in localizing parathyroid adenomas.[21]

[19] Guhr, B. C., and Shields, T. W.: Primary hyperparathyroidism, its varied clinical picture, Quart. Bull. Northwestern School Med. 32:244 (Fall) 1958.

[20] Randall, R. V., and Keating, F. R.: Serendipity in the diagnosis of primary hyperparathyroidism, Am. J. Med. Sci. 236:575 (Nov.) 1958.

[21] Steiner, R. E., Fraser, R., and Aird, S.: Operative parathyroid arteriography for location of parathyroid tumor, Brit. Med. J. 1:400 (Aug.) 1956.

EKG Findings

Electrocardiographic changes in hyperparathyroidism may include a decreased Q-T interval and a virtually absent ST segment. Prolongation of the PR interval has been observed. The Q-aT interval is measured from the beginning of the QRS to the apex of the T wave in whichever lead shows the tallest T wave. The Q-aT interval is easier to measure than the Q-T interval and is a readily measured index of shortened systole of hypercalcemia. A precocious apex of the T wave with a slow-descending limb in the precordial leads is another finding which may occur.[22]

Chemical Diagnosis

However, except for the relatively uncommon fully developed case of osteitis fibrosis cystica, the diagnosis of hyperparathyroidism is not a clinical or roentgenographic diagnosis but is a chemical diagnosis requiring laboratory confirmation. Unfortunately, there is no means available by which circulating parathormone may be measured. We must therefore rely on other laboratory tests, and there is no single test adequate to establish the diagnosis. The determination of the serum calcium and phosphorus levels is the most practical method of screening patients for hyperparathyroidism. Evidence is divided as to whether the serum calcium or the serum phosphate determination is the more helpful diagnostically.

Chambers *et al.*[23] and Frame and Haubrick[10] found that their patients often had high serum calcium levels and normal serum phosphorus levels while Schwartz[24] and Bogdonoff *et al.*[3] found the opposite to be true. The difference has been attributed to differences in dietary intake of the patients studied.

The parathyroid hormone controls only the ionized serum calcium and does not affect the protein bound calcium. Thus, it is possible for a patient with a low serum protein and consequently a low protein-bound calcium to have an elevated ionized serum calcium caused by hyperparathyroidism and yet have a normal serum calcium by a standard determination which measures the sum of the protein bound and ionized calcium. Thus, a false normal can be obtained under such circumstances, making it advisable to carry out serum protein determinations simultaneously with the measurement of the serum calcium. One should also remember that in some ulcer patients on a milk-alkali regimen hypercalcemia may develop, and this must be differentiated from primary hyperparathyroidism in hyperparathyroid cases with gastrointestinal manifestations. An elevated serum calcium is also found in hypervitaminosis D, multiple myeloma, sarcoid, hyperthyroidism, myeloma, metastatic malignancy, rapidly-developing osteoporosis of children, and disuse atrophy of bone such as in patients immobilized by fractures or paralysis. Secondary hyperparathyroidism must be distinguished from primary hyperparathyroidism. Secondary hyperparathyroidism may result from calcium deprivation, rickets, osteomalacia, biliary fistula, chronic jaundice, pregnancy, lactation, and chronic renal disease.

Heyman[5] has stressed that one should perform repeated serum calcium determinations in suspected cases of hyperparathyroidism as the serum calcium may be only minimally or intermittently elevated. At times, after several days of bedrest, an elevated serum calcium may be obtained in a patient with hyperparathyroidism who previously has had normal serum calcium values.

Calcium is present in plasma in ionized, complex, and protein-bound states. Although the three fractions are believed to be equilibrium with one another, the level of the ionized calcium is regarded as the most important related to the activity of the parathyroid.[25]

In their series of 17 cases, Lloyd and Rose[25] found the ionized calcium was raised before operation in every patient but one who was probably in temporary remission. After removal of the adenoma, the plasma ionized calcium always fell to normal or below normal. This fall was proportionately greater than the fall in the protein bound fraction. Measurement of the plasma ionized calcium is a valuable screening test for patients with "idiopathic hypercalcinuria" in order to exclude hyperparathyroidism. If the plasma ionized calcium is raised, the hypercalcinuria is not "idiopathic."

In evaluating the serum phosphorus in hyperparathyroidism, one should keep in mind that with concomitant renal disease, the urinary excretion of phosphorus may be depressed, thus raising the serum phosphorus. Thus, it is wise to obtain a urea nitrogen determination or similar test to evaluate the renal function when obtaining the serum phosphorus determination. In patients with ulcers or gastrointestinal symptoms, one must remember that non-absorbable aluminum gels appreciably reduce the quantity of phosphorus available from the intestine, resulting in a depressed value of the serum inorganic phosphorus.[10]

Another test which is of value in corroborating the diagnosis of hyperparathyroidism in suspected

[22] Beck, G. H., and Marriott, H. J. L.: The electrocardiogram in hyperparathyroidism, Am. J. Card. 3:411 (Mar.) 1959.

[23] Chambers, E. L., Jr., Gordan, G. S., Goldman, L., and Reifenstein, E. C., Jr.: Tests for hyperparathyroidism: tubular reabsorption of phosphate, deprivation and calcium infusion, J. Clin. Endocrinol. 16:1507 (Nov.) 1956.

[24] Schwartz, T. S.: Laboratory aids in the diagnosis of parathyroid disease, Med. Clin. North Am. 43:497 (Mar.) 1959.

[25] Lloyd, H. M., and Rose, G. A.: Ionized, protein-bound, and complexed calcium in the plasma in primary hyperparathyroidism, Lancet 2:1258 (Dec.) 1958.

cases is the renal tubular reabsorption of phosphate test (TRP). Normally, the renal tubules reabsorb 80 to 90 per cent of the phosphate filtered through the glomeruli. Parathyroid hormone inhibits this tubular reabsorption. In determining the TRP, an overnight (4-12 hours) urine specimen is collected and the total amount of phosphate and creatinine present is determined. A blood sample is drawn at the end of the collection period and the serum phosphate and creatinine levels are determined.

$$TRP = \frac{1 - \text{urine phosphate x serum creatinine}}{\text{urine creatinine x serum phosphate}}$$

A result of 83 per cent or less is thought to be significant and highly suggestive of hyperparathyroidism. This test, like the serum phosphate, is not reliable in the presence of renal insufficiency. As in the serum phosphorus determination, one must withdraw all antacid for 24 to 72 hours before the TRP test is performed, as aluminum gel ingestion reduces the absorbable phosphorus and decreases the urinary phosphorus excretion, thereby influencing the rate of renal tubular reabsorption.

Patients with primary hyperparathyroidism on a diet restricted in phosphorus (as occurs in most low calcium diets for renal calculus) may have a normal TRP. An abnormally low TRP may occur in multiple myeloma, osteomalacia, Cushing's disease, sarcoidosis, or Fanconi's syndrome.[19]

Another test which may be of value in corroborating the diagnosis of hyperparathyroidism is the 24-hour urinary calcium excretion test or calcium deprivation test. The patient is placed on a low calcium diet (125-150 mg per day) for three to seven days prior to collecting a 24-hour urine sample. The normal urinary excretion is less than 100 mg per day. Values above 125-150 mg are abnormal. In interpreting this test, one must remember that hypercalcinuria may occur in any condition characterized by rapid skeletal demineralization: in renal acidosis, in idiopathic hypercalcinuria (which is a common finding in urinary lithiasis) and in other conditions. This test may also be affected by renal insufficiency, inasmuch as the urine excretion of calcium may be decreased in urinary insufficiency. This test is often equivocal, or negative results are obtained, in patients with hyperparathyroidism who do not have elevated serum calcium levels.

The Sulkowitch test is not a very effective screening test for hyperparathyroidism. Its main value would seem to be in a persistently low value being presumptive evidence against the diagnosis of hyperparathyroidism.

The degree of elevation of the alkaline phosphatase in hyperparathyroidism is determined entirely by the extent of bone involvement and is of no diagnostic value. The serum alkaline phosphatase may be used as a screening measure for the detection of bone disease in hyperparathyroidism, since skeleton roentgenograms will be uniformly unrewarding in cases with normal alkaline phosphatase. The level of the calcium in the cerebrospinal fluid may be of diagnostic value in determining the cause of hypercalcemia.[26] In primary hyperparathyroidism, the rise in the cerebrospinal fluid calcium is not commensurate with the rise in the diffusible serum calcium concentration, whereas in hypercalcemia resulting from other causes, the rise in the cerebrospinal fluid level is consistent with the elevation in the diffusible serum calcium. The cortisone suppression tests may be of value in differentiating primary hyperparathyroidism from other hypercalcemic states in that the serum calcium level associated with primary hyperparathyroidism is not lowered by the administration of adrenal steroids. However, patients with hypercalcemia from other causes, especially sarcoidosis, will show a drop in the serum calcium level.

Other tests which may be of value in diagnosing the difficult case of hyperparathyroidism include the phosphate clearance test, the phosphate deprivation test,[25] the calcium tolerance test or calcium loading test,[27] the maximal tubular reabsorption capacity for phosphate test and the hypocalcemia responsiveness test,[23] measurement of the renal phosphorus threshold,[28] the Ellsworth-Howard test, the parathyroid activity index and calcium balance tests.[25] Radioactive strontium has been used for the diagnosis of hyperparathyroidism. Final evaluation of this procedure is not available as yet. Anomalies in the beta-1-globulin area of the serum in immunoelectrophoresis have been reported in hyperparathyroidism.[29] Hypomagnesemia has been found in association with hyperparathyroidism.

Summary

Since it is a systemic disease, the protean manifestations of hyperparathyroidism may affect any one or any combination of the body systems and may be encountered by any one of us regardless of his specialty. Certain aspects of hyperparathyroidism pertaining to the symptomatology, physical examination findings, roentgenographic findings, and laboratory findings have been reviewed.

[26] Williams, R. W.: Textbook of Endocrinology, 2d ed., Philadelphia, 1955, W. B. Saunders Co.
[27] Howard, J. E., Hopkins, T. R., and Connor, T. B.: On certain physiologic responses to intravenous injection of calcium salts into normal, hyperparathyroid and hypothyroid persons, J. Clin. Endocrinol. 13:1 (Jan.) 1953.
[28] Hyde, R. D., Jones, R. V., McSwiney, R. R., and Prunty, F. T. G.: Investigation of hyperparathyroidism in the absence of bone disease, Lancet 1:250 (Jan.) 1960.
[29] Komarkova, A., and Korinek, J.: Immunoelectrophoresis in patients with hyperparathyroidism, J. Lab. Clin. Med. 54:707 (Nov.) 1959.

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The President's Page



DR. BURDEN

The best news we have to bring you is, of course, the successful negotiation of a new basic contract and individual contract with HMSA. Congratulations are in order to the Medical Care Plans Committee of HCMS and especially to Dick Kennedy and Mr. Rice for the completion of a very much improved contract which provides the groundwork for further improvement of the services offered the public by HMSA.

For the first time in history, I believe, the membership of HCMS offered an almost united front and showed what could be accomplished by doing so. It is now up to all of us to offer a 100% united front in implementing these contracts in providing improved medical care to the people of Hawaii.

I especially appreciate the courtesy of HCMS in inviting representatives of the other county societies to attend the final session of the Medical Care Plans Committee so that they could have an opportunity to express themselves prior to finalization of the contract. This was done at the expense of HCMS. I would like to see this liaison continued in the future and I am certain that the neighbor island county societies would be more than glad to pay their own way if they could have representation on this very worthwhile and important committee.

The Stockton plan is progressing well and will soon be in active operation. There seems to be a misconception on the part of some that this plan conflicts with HMSA or will eventually replace the HMSA plans. The Stockton plan will not conflict with the existing HMSA plans, any more than the Community Plan did when it was initiated. It is merely a further expression of complete medical care on a service basis with free choice of physician. It will be sold by any or all insurance agencies and HMSA will be in a preferential position to bid successfully on all contracts because of their nonprofit status. It should further increase the percentage of the population covered by HMSA. It is up to us to see that this happens.

I would like to stress the importance of every doctor fully informing himself about the King-Anderson bill for tying hospitalization of the aged to the Social Security system. It is urgent that we take advantage of every opportunity to discuss the disadvantages of this bill and the advantages of the Kerr-Mills bill so that the King-Anderson bill will be defeated in the next session. It is alarming to note that the American Nurses Association recently went on record favoring the King-Anderson bill. Closer to home, only three of Hawaii's hospital administrators are definitely opposed to the King-Anderson bill while three have indicated they are in favor of it. This indicates a lack of liaison between the doctors and the administrative personnel of the hospitals. This condition can and should be corrected.

Courses of instruction for self care in time of mass casualties are being prepared and will be presented in the future. When they are, every physician should cooperate fully in implementing them. We cannot prepare too soon or too thoroughly for what we know is coming—how soon we do not know but current events indicate it might be sooner than many think.




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[EDITORIALS]

Medical Discipline

The remedy has to lie in some revision of the juridical process that will permit action against a known or suspected offender to be initiated from afar. Then Dr. A., knowing well that Dr. B. is something of a sinner, can still sit at his side in the locker-room and say to his friend, "Joe, they can't do this to you!"

If medicine is to keep its few graspers and fumblers from poisoning the well, however, somebody has to do it to Joe. In most cases, his friends at home aren't going to and shouldn't have to. . . . The ultimate solution is a central judiciary system that will take responsibility for initiating investigation and action on legitimate complaints. Local medical societies would lose a little autonomy, but it is better to lose autonomy than respect. The way things are going now, when Hippocrates is mentioned, somebody always laughs.

ROBERT M. CUNNINGHAM, JR.
Hospitals, Doctors and Dollars

Discipline of erring or incompetent physicians in the U. S. is left largely to state boards of medical examiners, individual hospitals, and county medical societies; state and other constitient medical associations, and the A.M.A. itself, have little to do with this problem. So found the A.M.A. Medical Disciplinary Committee (Raymond M. McKeown, Chairman) after a two-year study, the report of which has just been distributed after its approval by the House of Delegates.

Dr. McKeown's Committee did not report on actions taken by county medical societies or general hospitals, but did review the pattern of "grievance" committees, by whatever name, across the nation. Honolulu County Medical Society first established such a committee in 1948, and changed it to an elected Medical Practice Committee in 1954. The McKeown Committee found that "only a handful" of societies are opposed to giving publicity to the activities of grievance committees. It is widely believed that public confidence in the integrity of the committee is effectively promoted by such publicity.

The Committee strongly recommended that grievance committees act like grand juries, initiating action when advisable, rather than waiting for a written complaint from a physician about an offending colleague.

Revocation or suspension of medical license can be carried out for over 90 different reasons, no one of which is to be found in every state. Nine grounds are repeated in 30 or more state laws: drug addiction in 47 states, unprofessional conduct in 45; fraud in connection with obtaining a license in 44 states; alcoholism in 42, advertising in 40, abortions in 39, conviction of a felony in 38; conviction of an offense involving moral turpitude in 36 states; and mental incompetence in 32 states. The Washington State Medical Disciplinary Board Act is held up as a model for others.

Strong emphasis on medical discipline can be expected from the A.M.A. during the next few years. The last House of Delegates approved of the initiation of disciplinary action against a doctor at the national level, whether action had been taken locally or not. The House also urged all counties to report disciplinary actions to their state association, and the latter to report them to the A.M.A.

The title page of the McKeown Committee's report is half black and half white, and the first page says "'Tis neither black nor white." Such is medical discipline in the U. S. today.

National Foundation for Everything!

Two years ago this page carried an editorial entitled "The National Foundation for—Everything?" In it we outlined the extent to which the National Foundation (formerly for Infantile Paralysis) had invaded the fields of the Shriners' Hospitals, the Bureau of Crippled Children, the Bureau of Vocational Rehabilitation, and the National Society for Crippled Children and Adults.

We disapproved of this move, on the ground that poliomyelitis was still a serious problem in many areas, and by the Foundation's own statement still a serious financial problem in their own chapters. We suggested that the move was motivated either by embarrassment at having such enormous sums of money to spend, or by the instinct for self-preservation—since the problem of poliomyelitis seemed so near to permanent solution.

Our suggestion that the exclusion of congenital heart disease from the Foundation's program was solely a matter of current policy has proved to be quite correct. Last May 18, in an official release from the Foundation, congenital heart disease was specifically stated to be one object of the Foundation's concern.

National Foundation chapters are now authorized to use their funds to aid victims of "*all types* [the italics are their own] of congenital defects." These are said to "run a gamut from the simple birthmark to gross skeletal malformations [and to] include metabolic disorders and such familiar diseases as cystic fibrosis, congenital heart disease and muscular dystrophy." The chapters are also authorized to "support two new medical program activities: Special Treatment Centers for birth defects and arthritis (and polio), and Evaluation Clinics for birth defects and arthritis." The former must be located at a "major medical center," and the latter at "a community general hospital."

For the time being, this would appear to leave virus diseases and central nervous system disorders out in the cold; but they are not being forgotten: large sums are being allocated to medical schools and elsewhere for research and treatment in these fields.

A fundamental guiding principle of voluntary associations for the promotion of health has been to avoid duplication and overlapping of effort. Health Councils have been established in many cities, one of the primary functions of which is to review health association activities in order to prevent such overlapping.

The National Foundation, to all appearances, has been at pains to ignore this principle. Already invading the fields of at least four major national organizations, it has now invaded that of a fifth, the American Heart Association. The Foundation's statement that it will not duplicate assistance already being given by the government or other agencies is not reassuring. The fact is that there are many other agencies already deeply involved in the areas being invaded by the Foundation.

The American Cancer Society has announced publicly that the day the cancer problem is solved by the discovery of a specific cause and specific means of prevention or cure, or both, they will go out of business and turn their funds over to a foundation for distribution to other appropriate agencies. This is a "team" approach or attitude, which the National Foundation would have done well to emulate.

Instead, seeing the approaching end of the poliomyelitis problem, and having already found that the innocent public was willing to give far more money than could reasonably be used for polio today, they have reduced the reaction of self-preservation to the ultimate absurdity by taking on the task of financing research into, and treatment of, all virus diseases, all birth defects, arthritis, and all central nervous system disorders.

We said two years ago, and we say again, that we can understand this, but we cannot approve of it, and we will not support it. It is a move that reflects discreditably upon the entire voluntary health movement.

• • •

A Reply from the National Foundation

The conclusions and allegations of the editorial "National Foundation for Everything" suffer from a lack of factual substantiation.

For example, it is not correct that The National Foundation has invaded the fields of the Shriners' Hospitals, the Bureau of Crippled Children or the other organizations listed. We have worked diligently to avoid any overlapping of services whatsoever.

It is a fact that two years ago Polio was a serious problem in some areas and The National Foundation was having financial problems in meeting polio obligations on the part of some chapters. It is inconsistent for the editorial to cite our financial problems on the one hand and on the other to assert that we have enormous amounts of money to spend. The National Foundation has never built up large cash reserves, but instead has

devoted each year's contributions to current obligations and future research project commitments.

Exclusion of congenital heart disease from The National Foundation's original patient aid program in birth defects was a matter of policy, which provided for gradual beginnings in a vast field of endeavor. Who pays for congenital heart patients? Not the American Heart Association. In doing research on congenital anomalies, how can congenital heart disease be omitted?

Because chapters are authorized to use their funds to aid victims of all types of congenital defects does not mean they must or will do so. All chapter programs are planned around the needs of their particular communities. No chapter may establish or support special treatment centers or evaluations clinics without approval of chapter medical advisory committees. This leaves the decision as to need and value strictly up to the physicians themselves.

Virus diseases and central nervous system disorders are indeed not "being forgotten" in The National Foundation's programs in both clinical and basic research. The importance of broad, basic research cannot be denied. As for treatment itself, there is now far too little money available for clinical research, and The National Foundation recognizes the need for and value of this kind of research which cannot help but provide treatment.

It should be clear to anyone familiar with the nature of research that a local Health Council can play no part in this program since effective research cannot be confined to any one community, institution, or scientist. Nationwide efforts are needed to be most effective.

The National Foundation does not aid patients for whom adequate services are being provided by other agencies. The "adequacy" is determined locally by chapter medical advisory committees and other agencies.

It would not be appropriate for The National Foundation to comment on the policies or future intentions of another organization, such as the American Cancer Society. It is pertinent to state, however, that we expanded our program into the fields of birth defects and arthritis only after long study, and upon reaching the decision that we could best serve the nation's health needs in doing so.

It would not be incorrect to say that the public obviously has confidence in The National Foundation, and believes that an organization which played so great a role in conquering polio could also find answers to other crippling diseases. It should be remembered that there is no such thing as research exclusively limited to polio, because to conquer a specific disease, research has to be conducted on a broad, basic scale.

It is difficult, if not impossible, to include here the whole story of The National Foundation's program and concepts. Everyone has the right to hold any opinion on any subject, but that opinion can be correct or not, depending upon the facts used in reaching it. In this global fight against mankind's most dread afflictions, the help and support of everyone is essential to victory.

September 7, 1961

Honolulu Chapter, The National Foundation
Medical Advisory Committee
THOMAS S. BENNETT, M.D., *Chairman*

Nurses Support the King Bill

There are about 16,000,000 Americans over 65 years of age. Of this group, an estimated

0.5 million receive annuities they purchased
1.3 million receive private pensions
1.7 million receive retired employee benefits under Civil Service
1.7 million receive veterans' benefits
11 million receive OASDI benefits, and of these
6 million own their own homes, mortgage free
1 million own their own homes, with mortgage

The statement that 60% of this group have an income below $1,000 a year means little, since 64.4% of all Americans have an income below $1,000 a year. The figure includes family members without income as well as those with it. The aged are not a homogeneous group financially; in a recent survey, only 10% said they regarded their financial situation as precarious.

Miss Julia C. Thompson, national legislative representative for the American Nurses Association, overlooked a lot of these facts in her recent testimony before Congress in support of the King Bill, which would finance medical care through the Social Security program. She also disregarded the 5,000,000 aged persons who are not covered by Social Security, and the fact that the estimated cost of the King program is already being revised upward. At the moment the annual maximum payroll tax is expected to rise from $288 to $325 for every wage earner—and it would be the same for a man earning $100,000 a year as for one earning 5,000 annually.

Miss Thompson emphasized the need for nursing home care, but overlooked the fact that the King Bill provides for only 180 days of this, against an average nursing home stay of 2½ years. The Kerr-Mills Act, now law, provides generous Federal subsidy for any amount expended by the state for medical or hospital services to the needy aged.

Basically, as Mr. Ribicoff said with commendable if appalling frankness on CBS-TV last spring, the King Bill's purpose is not to aid the needy; it is to provide federally financed medical care and hospitalization to "the great middle class of the American public." The "need" is not humanitarian, but strictly socialistic dogma. And the cost would be borne, like that of the whole Social Security program, in very large measure by our children and grandchildren.

This is What's New!

Furaltadone (Altafur, Eaton Labs.) has been thoroughly **lambasted** as a chemotherapeutic agent in a series of articles appearing in the *New England Journal of Medicine* and *British Medical Journal*. Various investigators found practically no support of the manufacturer's claim that the drug provided effective antibacterial action in various infections, including staphylococcal infections. The *British Medical Journal* summed it up: "A chemical which inhibits growth on an agar plate is not necessarily a chemotherapeutic agent." McCarthy and Finland conclude that **Furaltadone cannot be recommended for therapeutic or prophylactic use.** The Food and Drug Administration under pending legislation will be authorized to require proof of efficacy as well as lack of toxicity before releasing a new drug for sale. (*New Eng. J. Med.* [July 6] 1961.)

Patients with degenerative or rheumatic **myocardial disease** may develop specific **anti-heart antibodies.** Myocardial damage results in the release of myoprotein which may in susceptible individuals act as antigen with resulting autoantibody production. The heart autoantibodies may be detected by the tanned red cell hemagglutination method. (*Lancet* [May 27] 1961.)

Patients with **gastric malignancy** have **fluorescent gastric juice sediment** after pretreatment with oral **tetracycline.** Seventeen out of 18 patients with gastric cancer showed a positive fluorescent test while 41 controls had negative tests. The tetracycline is administered orally for a week prior to performing the test. (*Gastroenterol.* [July] 1961.)

Southern urologists ask, **"Where are the early carcinomas of the prostate?"** They liken the situation to carcinoma of the cervix 30 or 40 years ago. They suggest that early diagnosis would make it possible to carry out **cures** rather than **palliation** in carcinoma of the prostate. (*So. Med. J.* [Apr.] 1961.)

George Griffith, writing in Los Angeles, discusses the **cardiovascular penalty for being a male.** Noting the greater incidence of myocardial infarctions and shorter life span along with limited loquacity in the male, he suggests that the more fragile men join the stronger sex by means of a **small daily dose of estrogen.** (*Ann. Int. Med.* [July] 1961.)

A **unilateral pulmonary infiltrate** seen on an x-ray film of he chest is usually attributable to inflammation or neoplasia. However, in a fair percentage of patients, this is due to **pulmonary congestion** with frequently a much better prognosis. (*New Eng. J. Med.* [June 1] 1961.)

Pathologists at the Royal Free Hospital in London make a plea for greater use of cytologic studies in the early detection of cancer. They note that Great Britain lags behind both the USSR and the USA in routine cytological examinations for cancer of the uterus in spite of the fact that cytologic method originated in England over 100 years ago when fragments of malignant tissue were detected in a patient's sputum. **Not mentioned as one of the reasons for the cytologic screening lag is the Ministry of Health's unofficial view that periodic examination of the apparently healthy person accomplishes nothing but to encourage hypochondriasis.** (*Brit. Med. J.* [June 24] 1961.)

Irving Wright and others at Bellevue and Cornell review trends in therapy of cerebrovascular disease. Regarding anticoagulant therapy in cerebral thrombosis, the authors are most enthusiastic about the use of **anticoagulants** in recurrent episodes of **transient cerebral ischemia.** They also present figures that indicate benefit from long-term therapy in the **recovery phase** after a cerebral thrombosis. However, they do not advise the routine use of anticoagulants in all patients with acute cerebral thromboses. (*Circulation* [Mar.] 1961.)

Twenty per cent of patients with **paralytic poliomyelitis** developed **hypertension** years after the onset of the acute paralysis. The incidence of the hypertension parallels the degree of skeletomuscle atrophy. (*Arch. Int. Med.* [Apr.] 1961.)

A Texas group re-evaluates **translumbar aortography.** Although they had six deaths in their first few hundred aortographs by the translumbar route, they have had no deaths or major complications in the last 1,625 aortographs. They emphasize that the patient be **well hydrated,** that the aorta be punctured **several centimeters proximal to the celiac axis,** and that **no more than 30 ml of contrast material** be injected. **Multiple** injections are **strictly avoided.** (*Surgery* [June] 1961.)

FRED I. GILBERT, JR., M.D.

THE DANGER OF SOCIALIZED MEDICINE

Is a very real one. However, as long as people can continue to adequately finance their own medical care through voluntary, pre-payment plans there will be little excuse for government interference in this area.

An ever present danger, which could weaken a pre-payment plan from within and open the flood gates of socialized medicine, is UNNECESSARY UTILIZATIONS OF BENEFITS. Physicians, hospitals and members by helping fight the UNNECESSARY UTILIZATION problem are in a very real sense fighting Socialized Medicine.

HAWAII MEDICAL SERVICE ASSOCIATION

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Dedicated to Proving that a Community Through the Cooperative Efforts of its People, Physicians and Hospitals can Best Solve its Own Medical Economic Problems.

Poisoning

Brief Reports on Poisoning from the Poison Control Center

For the past four years, the Poison Control Center at Children's Hospital has offered an invaluable poison information service to physicians. In addition, the Center has recorded many interesting cases of poisoning, which have come to our attention. Some of these have had therapy initiated promptly upon our recommendations.

Through the collection and interchange of data from the experiences of the Center, the attending physicians, and hospital personnel, the Poison Control Center plans to publish in the HAWAII MEDICAL JOURNAL, *instructive cases of poisoning occurring in Hawaii. It is hoped that this information will help to devise means for better prevention and more efficient treatment procedures.*

RICHARD K. B. HO, M.D.
Director
Poison Control Center

Organic Phosphate Poisoning

Case No. 1: This teen-age boy complained of severe stomach-ache shortly after dinner. According to his father, the patient had sprayed vegetables all afternoon with a potent insecticide containing parathion. The patient had several bouts of vomiting and was ordered to bed on suspicion of flu or food poisoning. He was quite restless throughout the night. About 13 hours from onset of symptoms, he vomited coffee-ground material and complained of violent abdominal cramps. He was rushed by ambulance to the hospital but expired enroute. It was later learned that the concentrate had been improperly diluted and the patient had used no protective devices.

Case No. 2: This two-year-old girl was admitted in coma following ingestion of unknown quantities of an insecticide containing malathion. Both pupils were constricted and did not react to light. The face was flushed and an increase in perspiration and salivation were noted. All reflexes were absent. Atropine (0.2 mg.) was given intravenously and repeated a short time later. The response was dramatic and the patient was discharged after three days of hospitalization.

Discussion

Both cases illustrate the dangers of organic phosphate insecticides. Parathion, as well as TEPP (tetraethylpyrophosphate), was derived from World War II researches on chemically related compounds known as "nerve gases." Malathion, though similar, is only about 1/100 as toxic. In the United States, outbreaks of occupational disease occur annually among crop workers. Several deaths through accidental ingestion by children have been reported. The mean lethal dose for an adult is probably 300 mg. (4 mg/kg).

Signs and Symptoms: Organic phosphate poisoning causes excessive cholinergic stimulation. Patients complain early of abdominal pain which is usually followed by vomiting and retching. An early warning sign of imminent toxicity is uncontrollable twitching of the eyelids. Perspiration, lacrimation, and increase in oropharyngeal secretions are frequent findings. Other signs and symptoms are flushing, dyspnea, weakness, dizziness, and numbness. Severe toxicity may terminate with convulsions, ataxia, coma and depression of the respiratory and circulatory centers. Anticholinesterase activity in the blood serum may be diminished.

A history of exposure may avert a tragedy of misdiagnosis since the presenting symptoms may be confused with the flu syndrome, food poisoning, gastroenteritis, or heat stroke.

One should note that poisoning may result from absorption through the skin, as well as the respiratory and digestive tracts. Improper dilution of concentrates, poorly designed protective devices, and careless handling have been cited as reasons for acute poisoning. The chemical residue on the surface of fruits and plants can remain toxic for days. Physicians should also be aware of air pollution problems that might affect surrounding housing areas.

Treatment:

1. Prompt removal from exposure. Wash any contaminated areas of skin and eyes.
2. Atropine—give intravenously in doses of 1-4 mg. (proportionately smaller doses for children). Repeat doses may be given at 15-60 minute intervals until atropinization is noted or no further signs of organic phosphate poisoning are present, especially excessive salivation. Patients poisoned by anti-cholinesterase organic phosphates are said to have increased tolerance for atropine.
3. Anticonvulsants — give whenever convulsions occur. (Do not give morphine, theophyllin or aminophyllin.)
4. Remove bronchial secretions and correct respiratory disturbances. (Note: Some insecticides contain hydrocarbons, such as xylene, kerosene, etc. Apply treatment accordingly.)
5. New drug — 2-pyridine aldoximine methiodide (2-PAM). For experimental use only (1-2 grams intravenously).

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In Memoriam - Doctors of Hawaii - XXXIV

This is the thirty-fourth installment of In Memoriam—Doctors of Hawaii.

Alfred Herbert Waterhouse

Alfred Herbert Waterhouse was born at Cedar Rapids, Iowa, on August 12, 1877, the son of William and Melicent P. (Smith) Waterhouse. He was a descendant of Hawaii's pioneer families on both sides. His grandparents, John Thomas and Eleanor Dickenson Waterhouse, came from Tasmania to Hawaii in 1851 to found the family here. William Waterhouse, the doctor's father, was the youngest son of this couple.



DR. WATERHOUSE

In 1897 the family moved to Pasadena, California.

Alfred's preliminary education was received at the Princeton preparatory school. From there he went on to Princeton University where he was granted his A.B. degree in 1902. While at Princeton his two most enjoyable courses were Political Science under Woodrow Wilson and English Literature under Henry Van Dyke. In 1906 he received his M.D. degree from Rush Medical College. Dr. Waterhouse interned at Silver Cross Hospital at Joliet, Illinois, from June, 1906, to June, 1907. In February, 1926, he took postgraduate work at the Mayo Clinic.

Dr. Waterhouse married Mabel Z. Palmer at Irwindale, California, on July 4, 1907. The couple had three children, William Allen, Florence Melicent and Marjorie May.

In July and August, 1907, Dr. Waterhouse went to the Navajo Reservation at Ganada, Arizona.

In September of the same year the doctor and his bride came to Koloa, Kauai, where he became resident physician for the Koloa Sugar Co., Ltd., and government physician for the district. He made his residence in the old Smith homestead at Koloa and maintained the old adobe house in which his mother, Melicent Philena Smith, had been born. Dr. Waterhouse served as government port doctor for Kauai as well as being the Board of Health doctor for the Koloa district.

Coming as he did in the horse and buggy days when many calls were made on horseback carrying saddle bags, Dr. Waterhouse was instrumental in establishing many medical milestones on Kauai. It was he who secured the first resident dentist at Koloa as well as the first eye, ear, nose, and throat specialist. He also established the first medical laboratory on Kauai and was one of the first to set up prenatal care and baby clinics on the Island. In 1910 he saw the Koloa Plantation Hospital built and had physiotherapy equipment installed in 1926.

In 1933 he retired as plantation physician and devoted his time to private practice.

In addition to resuming the medical career of his missionary grandfather, Dr. Waterhouse served on the Board of Trustees of the Koloa Union Church, which was founded by the missionaries and maintained by his family. He also taught a Sunday School class of junior high school boys.

Dr. Waterhouse was appointed Commissioner of Public Instruction from Kauai in 1934 and served in this capacity until 1945. At the same time he served as a trustee of the Samuel Mahelona Hospital at Kapaa. During the war Dr. Waterhouse was Secretary of the Medical Advisory Board of the Selective Service Draft Committee.

In 1947 the doctor celebrated his 70th birthday at the family residence on Koloa with a party for 100 of his old friends.

On December 24, 1948, at the age of 71, Dr. Waterhouse died.

He was the first president of the Tuberculosis Association on Kauai, a member of the Hawaii Medical Society, a Boy Scout sponsor and member of the board, member of the board of the Salvation Army of Kauai, member of the Board of Trustees for Kukuiolono Park and a member of Alpha Kappa Kappa fraternity.

Charles Paul Durney

Charles Paul Durney was born at Columbus, Ohio, on November 19, 1887. He was the son of Daniel John and Mary Elizabeth (O'Sullivan) Durney.

His preliminary education was received in the public schools in Kenova, West Virginia, and at Miles City, Montana. He then attended Marshall College, Huntington, West Virginia, and graduated from Georgetown University Medical School in Washington, D. C., in 1909.

On December 7, 1910, Dr. Durney married Margaret May Bell. The couple had three children: Margaret Louise, Marie Rennis, and Charles Paul Durney, Jr.

A vacation trip brought Dr. Durney to Hawaii in 1910, and he remained to practice medicine. He was first appointed government physician in the Kahuku district of Oahu. He also served as physician for Kahuku and Laie plantations and Koolau Railroad Co. Later he became government physician for the Koolaupoko district and surgeon for Libby, McNeil & Libby.

In 1912 Dr. Durney was appointed medical superintendent of Kula Sanatorium on Maui. From 1912 to 1925 under his care the institution grew to 250 beds and became a real influence in the tuberculosis field throughout the Islands.

In 1925, due to his desire to educate his children on the mainland, Dr. Durney left Kula to become associated with Dr. George H. Evans and Dr. Philip King Brown at Alum Rock Sanatorium in San Jose, California. He worked not only in this institution but throughout the community in association with tuberculosis clinics and the Santa Clara County Tuberculosis and Health Association.

Dr. Durney died March 19, 1932, in San Jose at the age of 44.

He was a member of the San Jose County Medical Society, the California Medical Association, the American Medical Association, the California Tuberculosis Association, the Laennec Society of Northern California, and the San Jose Lions Club.

Book Reviews

★Gastric Cytology, Principles, Methods, and Results

By Rudolf Otto Karl Schade, M.D. (Dunelm), M.D. (Tubingen), I.R.C.P., M.R.C.S., 83 pp., $8.00, The Williams & Wilkins Co., 1960.

This is an excellent monograph on the subject of gastric cytology. It begins with a historical review of the attack on gastric cancer. Stress is placed on the importance of new methods for early diagnosis to improve survival rate. A history of gastric cytology is presented and the basis of cytologic study is discussed. There is a plea for the use of both histology and cytology side by side. Techniques for collection of material are described and evaluated. Smear staining, scanning, and classification are also dealt with. A description of a method of photomicrography of cytologic preparation is an unusual addition to the text. Then normal and abnormal cells in various conditions are described. The text finishes with presentation of results.

This, however, is not the end of the volume, since here follow numerous black and white photomicrographs and some diagrams illustrating many facets of gastric cytologic study. A few gross pictures are presented. The photographs can be interpreted by the expert cytologist, but lack of color is as always a drawback for the non-cytologist. Furthermore, at times the magnification seems poorly chosen. In general, however, the pictures are an excellent guide for those with basic knowledge in gastric cytology and the text is an excellent introduction for beginners in the field.

Physically the book is well bound, the print is large and readable, and the contents and bibliography are adequate. Lack of an index is not a great drawback in such a small volume.

W. Harold Civin, M.D.

★Handbook of Surgery

John L. Wilson, M.D., Editor, 644 pp., $4.00, Lange Medical Publications, 1960.

This is a handy reference book; an index gives the reader quick access to specific surgical entities, their clinical findings, diagnosis, and treatment. The title refers to surgery in general and includes the surgical specialties (gynecology, urology, neurosurgery, and traumatic orthopedic surgery) as well as all phases of general surgery. It is complete. It appears to be up to date; it includes specific references to the literature as late as 1958 (Wangensteen's intragastric cooling for massive gastrointestinal hemorrhage). It includes basic concepts in the discussion of classic entities; i.e., Haagensen's criteria of operability in carcinoma of the breast.

In the discussion of some subjects, on the other hand, it mentions techniques which are somewhat outmoded; i.e., the injection of ether through a T-tube to dissolve a retained common duct calculus. Occasional well-drawn illustrations and charts lend clarity to the text. Minor disadvantages are the small print and lack of bibliography.

In general, this is a book which would be of value in the hip pocket or on the bedside table of every surgical intern and resident, and of every practicing surgeon also.

C. S. Judd, Jr., M.D.

★ Highly recommended.

Back Pain

By John McM. Mennell, M.D., 226 pp., $9.50, Little, Brown & Co., 1960.

The first 38 pages set the tone for the entire volume. Those who can understand and accept the author's concepts of "joint play," "joint lock," and "joint dysfunction" should read on. They will find this volume an all-encompassing monograph of diagnosis (which is described as obvious most of the time, if the author's techniques of examination are followed) and of treatment by manipulation of almost any condition of any part of the vertebral column that is or ever has been reasonably proved to be a cause of neck or low back pain.

The entire field of ruptured disc diagnosis and surgery is passed off in relatively few pages, and his picture is certainly a discouraging one for those unfortunate surgeons engaged in this field of surgery. The fact that several congenital anomalies about the lumbosacral articulation have been listed as causes of low back pain, though these same anomalies have been rather conclusively shown to be insignificant factors as causes of pain by elaborate well-controlled x-ray and pre-employment physical examinations with adequate post-employment followup, makes me reluctant to accept at face value much that is written.

The whole volume smacks of my idea of osteopathy.

Donald A. Jones, M.D.

The Other Child. The Brain Injured Child, 2d Ed.

By Richard S. Lewis, Alfred A. Strauss, and Laura E. Lehtinen, 148 pp., $3.75, Grune & Stratton, 1960.

The book deals with the problems of brain damaged children which perplex those who are entrusted with their care, whether it be the parents or others. There are few physicians who can take the time to help those caring for the brain damaged child to understand them. Physicians should know that this book exists and prescribe it for parents who need all the help they can get. How any single community deals with training for their children outside of the home can't be spelled out. However, parents familiar with the material in this book could band together and, with the guidance of child psychologists and teachers, might well develop a program in any community and share in its operation.

R. Frederick Shepard, M.D.

★Radiation—Use and Control in Industrial Application

By Charles W. Shilling, M.D., Sc.D., 223 pp., $6.75, Grune & Stratton, 1960.

The atomic age is persistently pressing itself upon the consciousness of the practicing physician. When the patient asks whether an x-ray or radioisotope procedure will harm him or his offspring, the question cannot be ignored and the physician can no longer afford to be ignorant or hazy in his answers.

In straightforward, non-technical terms, the present monograph—by the Deputy Director, Division of Biology and Medicine, U. S. Atomic Energy Commission—provides a rational approach to the radiation problems

(Continued on page 88)

Hawaii Medical Association

AMA Delegate's Report

The 110th meeting of the AMA was held in New York City from June 25 to 30. Two hundred sixteen delegates met in the Statler-Hilton Hotel to act on 28 reports and 115 resolutions, thought to be the largest number ever presented.

MEDICAL DISCIPLINE

A 76-page report of the Medical Disciplinary Committee, emphasized in the address of the President, Dr. Leonard Larson, was approved by the House without dissent. Noteworthy recommendations in it:

1. That the AMA be enabled to suspend or revoke membership regardless of whether or not action has been taken at a local level.
2. That both county and state societies use their grievance or medical practice committees as "grand juries" to initiate needed actions.

PARAMEDICAL PROFESSIONS

So vehement were the protests against the Trustees' recommendation that a new Council be formed to deal with problems relating to other health professions and services (psychologists, optometrists, podiatrists, etc.) that the House established a "Commission" of seven, to be appointed by the Speaker, for this purpose. Subcommittees of three to five members, selected by the Commission from lists of names submitted by the various AMA Sections, will consider problems in specific areas.

"ABDOMINAL" SURGEONS

Diplomates of the wildcat "American Board of Abdominal Surgery" and their sympathizers "packed" the meeting of the Section on General Surgery, threw out the men chosen by the nominating committee, elected their own slate of officers, and passed resolutions adding five "officers-at-large" to the Section's Executive Committee and officially approving of the American Board of Abdominal Surgery. No one appeared before the Reference Committee to support the resolutions, however, so the House upheld the Committee's recommendation that they be not adopted. The vulnerable democratic process in the Section meeting had been successfully backstopped by the less vulnerable republican process in the House of Delegates. The Section on General Surgery may need to meet in the Yankee Stadium next year!

OSTEOPATHY

Policy regarding osteopathy was handed back

(Continued on page 74)

MINUTES OF THE COUNCIL MEETING

July 21, 1961, at 5:30 p.m.
Pacific Club, Honolulu

PRESENT

Dr. J. A. Burden, presiding; Drs. Allison, Andrews, Benson, Giles, Goodhue, Nishijima, Richert, and West plus guests, Messrs. Lytle and Kennedy and Dr. Arnold.

MINUTES

The minutes of the March 27, 1961, meeting were approved as published.

HMSA SPONSORSHIP

A letter from the National Association of Blue Shield Plans dated July 14 states that they have nothing in their files showing when HMSA originally received medical society approval. Dr. West noted that the Honolulu County Medical Society was the first to sponsor the HMSA. Dr. Burden said the House of Delegates could be called upon to endorse the HMSA at the state level.

OASI FORMS

The request that each county medical society contact its Social Security office to get them to agree to a stipulated fee for filling out forms received only one reply, from Hawaii. The Maui and Kauai representatives advised that this matter had not been brought before their societies and it was agreed to send a follow-up letter.

MEDICAL CAREER RECRUITING

Correspondence with Dr. William F. Moore, Jr., relative to establishing a recruiting committee, was read. Dr. Richert suggested that this be tied in somehow with the Governor's Committee on Higher Education which deals with medical education in the thirteen western states participating in WICHE. He gave a brief outline of this committee's activities. Dr. Giles advised that the Health Education Committee has also been discussing this subject and that should be taken into consideration when the activities of the appointed committee are designated. Dr. Nishijima questioned whether we have the same trouble here as on the mainland. Dr. Richert advised that at the present time there are some 36 men from Hawaii studying medicine. About 12 or 13 enter medical school each year. Dr. West noted that statistics show that the number of doctors in proportion to the population is getting less and less and that it doesn't mean that everyone who studies on the mainland will come back here to practice. The purpose of this program would be to get better students interested in studying medicine. Dr. Allison felt that the Health Education Committee should be relieved of its part in this program.

ACTION:

A motion to approve the formation of a committee to promote Careers Day was seconded and passed.

PODIATRY IN HOSPITALS

A request to support the American Academy of Orthopaedic Surgeons' position on the practice of podiatry in hospitals was read. Dr. Arnold spoke on the extensive discussions of this subject at the AMA meeting and outlined the make-up of the commission that is being formed to handle problems relating to paramedical groups. It

(Continued on page 80)

Notes and News

Names in the News

The profession, especially the General Practitioners, ave lost a good colleague in **Dr. Kenneth K. O. Ching** who unexpectedly passed away. He was only 39.

Recent heart research grant recipients were **Drs. M. E. erk, A. S. Hartwell, L. T. Chun, Paul Gebauer,** and **ernard Yim.** Drs. Berk and Hartwell are to continue ie Hawaii ethnic survey on atherosclerosis. Dr. Chun's roject, centered at Children's, will involve study of the eta hemolytic streptococcus. Dr. Gebauer will continue open heart surgery.

Dr. William John Holmes has been elected a member f the Oxford Ophthalmological Congress. In July he elivered a lecture to this group. He also made news ith his newspaper article entitled "Information is Great Need for Better Health in Asia."

Dr. and Mrs. Edmund Lee had quite a spread in the ociety columns for the "Chinese" Baby "luau" they ad at the Hawaiian Village Longhouse.

Four doctors' offices at the Central Medical Building ere entered by burglars recently. Total loss was $5.00 rom **Dr. Robert Katsuki's** office—mighty small pickings!

Speeding, screaming ambulances continue to make eadlines. Pertinent comments were made by **Drs. F. J. inkerton, Joseph Strode, David Katsuki,** and **Oscar reech,** a visiting professor from New Orleans.

Dr. Joseph Palma made national headlines with his iews on medical training of doctors and in govern- nental treatment of doctors, combining to impair serv- es to patients. His comments were made at the recent MA meeting, pediatrics section, and were picked up by he wire services.

Loss of a prized cat, "Ralph," caused **Dr. Walt Quisen- erry's** son to be heartbroken.

Doctors from the State Hospital (Cody and Spero) ith **Dr. Richard K. C. Lee,** Health Department head, nade interesting news when a convicted burglar and an ccused killer "walked" out from the hospital. New ecurity measures will probably result from this.

Dr. Paul G. Stevens from Molokai was very pleased t the $250,000 state appropriation towards the construction of a much needed general hospital on his island which will replace the present outmoded firetrap.

Dr. Robert Spencer stressed new treatments in mental diseases and received complimentary comments from the press.

The HMSA-HCMS hassle is making noteworthy news. Even HMA President, **J. Alfred Burden,** got into the picture.

Dr. Norma Sneed of Queen's looked professional in a picture published in a local paper concerning a story on the artificial kidney at that hospital.

Dr. Richard You was elected co-chairman of the Korean Community Council.

Dr. Robert Chung made the front pages when he was nominated for membership in the Oahu School Advisory Council, but was subsequently rejected by the City Council.

Plans and groundbreaking ceremonies for the new Hawaii Medical Library Building were much in the news recently. Participating in the ceremonies, their happy faces prominently displayed in the local paper, were **Drs. Grover Batten, Fred Giles, Henry Gotshalk, A. S. Hartwell,** and **Richard Lee.**

Dr. John Bell seems to be spending much time on golf. His 4 up on par was winner at a recent O.C.C. tournament.

Socialite **Dr. C. W. Trexler** looked handsomely young in a picture he had taken with General Sabini at the Italian consulate's centennial celebration. **Dr. and Mrs. Les Vasconcellos** attended the same party and made a handsome couple on the society page. Trex's picture was also conspicuous as the installing officer of the new officers of the Honolulu Lions Club.

Congratulations to . . .

The Kaiser Foundation Hospital, for full accreditation by the Joint Committee of Accreditation of Hospitals.

Dr. Katherine J. Edgar and **Dr. Carolina Dizon Wong,** whose careers were feature articles in the local papers. They made fine interesting reading.

(Continued on page 76)

KENNETH K. O. CHING, M.D.
1922-1961

Kenneth K. O. Ching, son of Mrs. Sam Yee Ching and the late Mr. Ching of Honolulu, was born on April 23, 1922. Following his graduation from St. Louis College in 1943, he attended the University of Hawaii for two years. After three years of service in the United States Army, Kenneth left for Dayton, Ohio, where he completed his pre-medical studies in 1948.

In 1953, he received his medical degree from Loyola Medical School in Chicago and returned to Hawaii to intern at The Queen's Hospital, then as a surgery resident at St. Francis Hospital for another year. Kenneth was then associated with Children's Hospital as a surgical assistant for 1½ years. Besides being in general practice in Kalihi, he had been a C & C physician from 1955 to 1960.

In 1946, Kenneth married Lily H. Hee, daughter of Mr. and Mrs. Hoy Hee of Honolulu. They have three children, Kenneth K. Y., Anthony Xavier, and Bernadette Ann.

He had always enjoyed golf and was a member of Moanalua Golf Club. He was also active in the following societies: Honolulu County Medical Society, Academy of General Practice, Hawaii Catholic Physicians Guild, Ching Clan Benevolent Society, See Dai Doo Society, Xavier Club, Cathedral Choir Chorus Club, St. John's Holy Name Society, and many others.

On June 12, 1961, Dr. Kenneth K. O. Ching passed away, at the age of 39.

WILLIAM L. DANG, M.D.

County Society Reports

Hawaii

The regular meeting of the Hawaii County Medical Society was held at the Tropics Lanai as a dinner meeting on June 8, 1961. Guests present were Dr. George Bracher, Dr. N. Sloan, Mr. & Mrs. Droste, Charles Dahlberg, Duncan MacNaughton, Paula Kimi, and LeRoy Andrews.

Awards were presented to winners of the recent essay contest (County, State, and National levels) to Charles Dahlberg ($50.00), Duncan MacNaughton ($25.00), Paula Ann H. Kimi ($15.00), and LeRoy M. Andrews ($10.00).

The membership was then informed that Mrs. Janet Lang was the recepient of the Hawaii County Medical Society scholarship to the University of Hawaii.

A discussion then followed in regard to the question of signing new contracts with the HMSA as individual participants or as a group through the County Medical Society. After a lengthy discussion, Dr. Henderson moved that we support the action of the Honolulu County Medical Society in requesting the individual doctors to delay signing as individuals until the negotiating committee of the Honolulu County Medical Society gives a report. This was seconded by Dr. Wipperman. The motion was defeated.

Dr. Steuermann moved, seconded by Dr. Henderson, that we ask Dr. George Mills to come to Hilo and explain the "Stockton Plan" at a breakfast meeting to be held on Sunday, June 25, at 7:30 A.M. The motion was carried unanimously.

Dr. George Bracher then gave an interesting talk on "Pelvic Carcinomas" following the business portion of the meeting.

* * *

A special breakfast meeting of the Hawaii County Medical Society was held at the Hilo Hotel on June 25, 1961. Guests present were Drs. George Mills, George Bracher, and M. Faus.

The meeting was called to order by Vice-President Pete Okumoto at 7:55 A.M.

Dr. George Mills then spoke on the "Honolulu Foundation Plan" followed by a question and answer period. The meeting adjourned at 10:15 A.M.

* * *

The July 27, 1961 meeting of the Hawaii County Medical Society was held at the Hilo Hotel. Guests present were Drs. Grover Batten, from Honolulu, Best, George Bracher, and P. Walsh.

Dr. Wilmot Boone's application for membership into the Society was approved unanimously.

The membership voted to invite Dr. Nesselrod, a proctologist from California, to conduct a two-day meeting in Hilo on Oct. 12 and 13, 1961.

Dr. Grover Batten then gave an interesting talk on "Cancer of the Thyroid" following the business portion of the meeting. He also commented on the workings of the Tumor Registry.

Following this a short movie was shown on cancer of the rectum and colon. This was a preview, preparatory to showing the movie to the public.

FRANCIS F. C. WONG, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met on Tuesday, June 6, 1961 at 7:30 P.M. in the Mabel Smyth Auditorium. Approximately 240 members were present.

A movie on Aerial Medical Research was shown and the speaker was Lt. Col. F. S. Spiegel, MC, Diplomate of the American Board in Aviation Medicine.

Presentation of Awards to 1961 AAPS Contest Winners:

Honolulu County Winners: Certificates presented by Dr. Hartwell
1st place—Harriet Fishel, $75 stock certificate
2nd place—Sylvia Yanagisako, $35 stock certificate
3rd place—Thomas Cordes, $20 stock certificate
4th place—Jeffrey Gordon, $20 stock certificate
State Winner: Award presented by Dr. F. L. Giles
1st place—Harriet Fishel, $100
National Winner: Award presented by Dr. F. J. Pinkerton
11th place—Harriet Fishel, $75

The following new active members were welcomed into the Society by Dr. Richard Moore: Drs. John F. Hanley, Doris R. Jasinski, Robert A. Nordyke, and George F. Parker.

A letter from Dr. Robert D. Millard submitting his resignation from the Board of Censors was read. The Chair explained that at the last election the Nominating Committee nominated Dr. Millard who is not a past president of the Society and cannot serve as a member of the Board of Censors. Dr. Millard has been replaced by Dr. Douglas Bell.

House Resolution 108 adopted by the House of Representatives of the First Legislature of the State of Hawaii in honor of Doctor's Day was read.

Dr. Richard Lee asked for volunteers to be on call to care for emergency medical needs of approximately 600 or more foreign participants attending the Pacific Science Congress. Doctors who would like to help out were asked to call either Dr. Mills, Dr. Lee or the Executive Secretary of the Medical Society.

The doctors were reminded to turn in their applications for membership in the Honolulu Foundation for Medical Care if they had not done so already.

The Chair announced that an ad hoc committee has been appointed to study the future staffing of Maluhia Hospital. Dr. Giles, chairman of the committee, reported that a first meeting has been held and that a report would be forthcoming.

Dr. Batten reported that the plans and specifications for the Medical Library have been sent out and that bids will open the first of the month. He stated that it is anticipated that construction will begin the first of August.

HCMS-HMSA:

Dr. Hartwell announced that tonight's discussion is a result of a letter received from HMSA notifying the Medical Society that they wish to terminate the basic contract as of June 30, 1961. Before proceeding with the discussion he requested all non-members of the Society to leave the meeting, then spent a few minutes outlining what the officers and Board of Governors have been doing with regard to HMSA. He reviewed briefly the history of the County Medical Society and HMSA's relationship and presented in chronological order the events leading up to the letter of termination from HMSA. He then asked the membership to bear in mind

(Continued on page 76)



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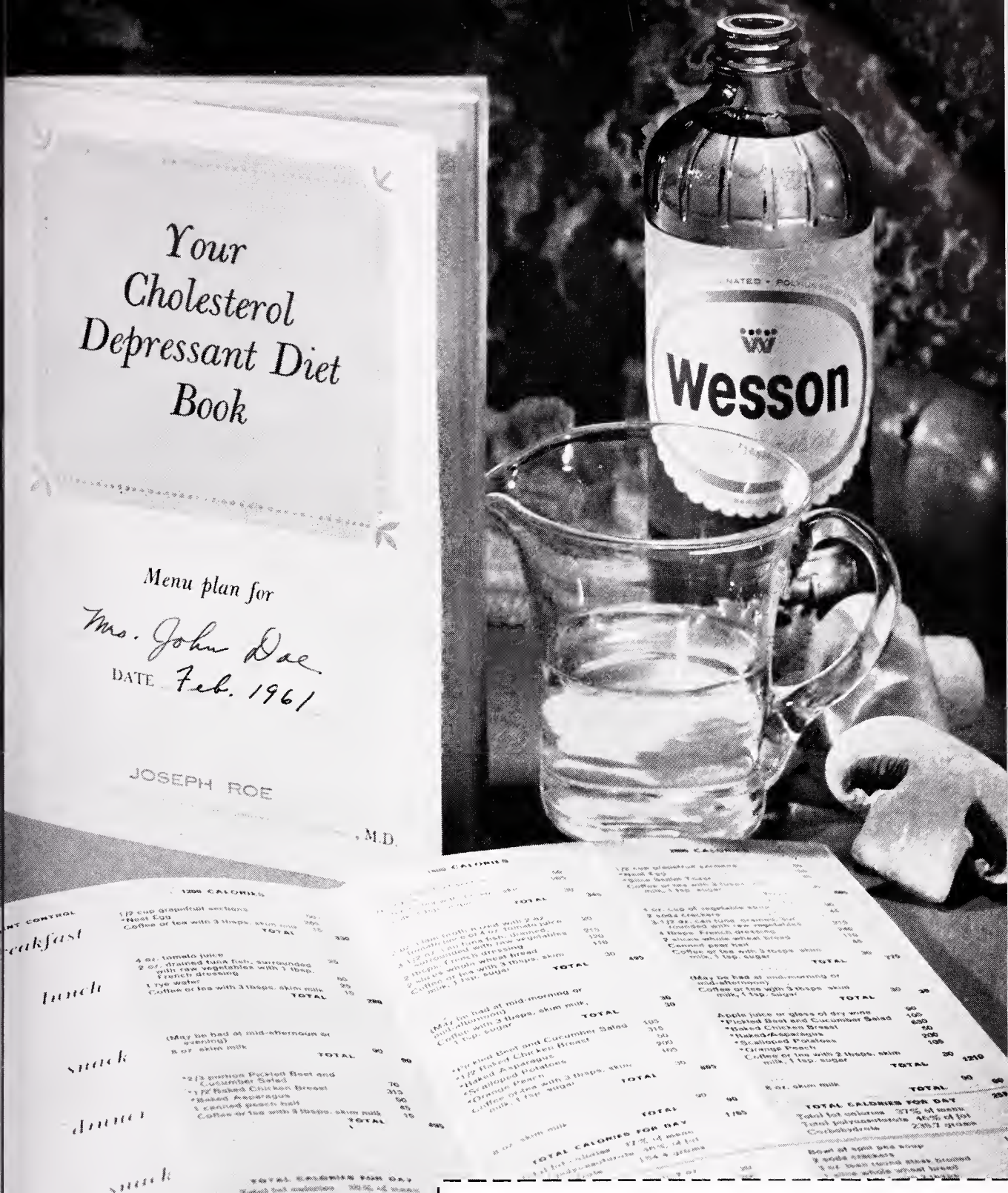
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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

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FLORA OZAKI, *Associate Editor*
KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

ROSE ANN POYZER, *Executive Secretary*

Expansion of ANA Functions Considered

How can ANA best meet emerging clinical interests of nurses while, at the same time, retaining and improving the important functions which it presently carries?

This was the major question for discussion at a June meeting of the ANA Board of Directors and a three-day joint session with state nurses association presidents and executive secretaries.

Basis for the discussion was a progress report, presented after nearly two years of study, by the Special Study Committee on the Functions of the ANA.

In its report the Committee pointed out that increasing specialization in the health field, including nursing, has brought about the development of special clinical concerns on the part of nurses. While nurses have organized ANA Conference Groups on Operating Room Nursing, Psychiatric Nursing Practice, and Maternal and Child Health, there is no way at present for adequately serving current clinical interests of nurses or providing for anticipated continued development within specialized areas of nursing.

The report also focused on other functions which the committee believes ANA should carry in fulfilling its obligations to members and the public, and suggested possible rearrangements within ANA that would make it possible for the association to assume additional responsibilities.

The Board, after discussion with state association representatives:

- approved the establishment of a committee on nursing education and a committee on nursing service but deferred appointment of the committees pending further suggestions from the Study Committee as to the scope of their responsibilities.

  The Study Committee suggested that an initial task of these committees should be the development of standards of nursing education and nursing service.
- authorized officers of the ANA Conference Group on Psychiatric Nursing Practice to begin work on defining levels and standards of practice within psychiatric nursing.
- authorized officers of the ANA Conference Group for Operating Room Nurses to begin work on standards for nursing care in the operating room.

  Work on these will be started at scheduled meetings of these two conference groups in September.
- approved the establishment of a joint committee on the ANA and the National Student Nurses' Association for consideration of common interests and goals for the nursing professions and those preparing to enter the profession and relationships of the two organizations.

  Appointed to the committee were Margaret McLaughlin, Virginia; Helen Hanson, Minnesota, and Carolyn Widmer, Connecticut.
- requested the Study Committee to continue with its investigation of areas requiring attention of the professional organization and to provide further elaboration of proposals in the present report.

State Representatives Meet

Nearly 100 state nurses association presidents and executive secretaries attended the three-day meeting in New York, June 26-28, to discuss with the Board of Directors major issues before the profession and the ANA.

Topics discussed included membership problems, relationships with state boards of nursing, and legislation.

Study Planned on Education Report

Interpretative materials for use by SNA's in promoting study of the May 1960 convention report on nursing education will be prepared by the EACT Section.

The 1960 report, prepared by ANA's Committee on Current and Long-Term Goals, included 12 principles of nursing education and a proposed goal, for consideration by the profession, that within the next 20-30 years the education basic to the practice of nursing on a professional level,

nclude components of both a professional and beral education and that toward that end, ANA nould promote the baccalaureate program.

The Board affirmed its belief in the substance f the proposed goal and authorized the EACT ction to proceed with the development of in- rpretive materials and preparation of a progress eport for presentation to the House of Delegates 1962.

Central Billing

ANA is investigating the possibility of insti- ting a centralized billing system whereby mem- ers would pay dues directly to ANA rather than states or districts as at present.

It is believed that such a system would prove n increased convenience to members and result n considerable savings to state and district as- ociations. It would also enable ANA to keep its nembership list up to date.

Also under consideration are payment plans nat would enable members who so desired to pay ues in installments.

Plans are still tentative, and it will require nsiderable time to work out the innumerable etails involved in such a plan, initiate a cen- alized billing system, acquire and install neces- ary equipment. The Board authorized the onstitution and Bylaws Committee to prepare roposals for bylaws changes that would permit entralized billing.

Registries Program

Increased ANA assistance to bring about the xpansion and improvement of nurses' profes- ional registries was recommended in a report rom ANA's committee on registries.

Proposals for providing additional assistance vere based on study conducted by ANA to ap- raise the problems and current effectiveness of rofessional registries. There are currently 163 egistries approved by state associations, the ma- ority operated by district nurses associations. ANA sets standards to guide the SNA's and pro- ide advisory service.

The Board approved that expansion of the pro- gram proceed as funds can be made available.

Convention Plans Reported

A total of one full day devoted to major clinical reas of nursing practice will be a new feature of ANA's 1962 convention, May 14-18, in Detroit. The clinical sessions will be held on Tuesday fternoon, May 15, and Thursday morning, May 16. They are being planned in addition to section program meetings on functional areas of profes- ional nursing.

"Relationships Between the Registered Professional Nurse and the Licensed Practical Nurse" will be the topic for one of four general program sessions.

A program on national defense, "Wake Up and Live" will feature a skit by members of the staff college, Office of Civilian and Defense Mobilization, followed by a panel discussion. The program will focus on relationships among the various governmental groups and organizations involved in civil defense planning, including state and district nurses associations.

The Counselors, Executive Secretaries, and Registrars Section will have a program on employment problems of those in the middle management field.

"The Education of Nurses Today and Tomorrow" will be the topic for the program of the Educational Administrators, Consultants and Teachers Section.

General Duty Nurses, Private Duty Nurses and Nursing Service Administrators Sections are planning a joint program on "Continuity of Patient Care." The NSA Section will also have a program meeting on research.

At the Occupational Health Nurses Section program, members will hear a talk on "Basic Aspects of Occupational Health Nursing Programs."

The professional nursing functions of the office nurse and their priority over other activities will be the focus of a symposium being planned by the Office Nurses Section.

A physician speaker and a panel of public health nurses will discuss "Your Mental Health as it Affects Your Performance and Satisfaction in Public Health Nursing" at the Public Health Nurses Section program.

Members of the Conference Group on Research will hear a technical discussion for researchers on "Defensible Criteria and Tools for Assessing the Quality of Nursing Care."

Guests at Meeting

Two officers of the National Student Nurses' Association were guests at the ANA Board of Directors meeting: Sally Schnur, Arizona, president, and Bev McCaig, Washington, first vice-president.

ANA Testifies for King Bill

The American Nurses' Association testified in support of health insurance for the aged under social security in hearings being held by the House Ways and Means Committee on the Kennedy Administration proposal, introduced by Rep. Cecil King (D., Calif.).

Pointing out that a larger financial burden will have to be borne by the public as the number of retired aged increases, Julia C. Thompson, R. N., ANA's Washington representative, said:

"Certainly, insurance premiums paid during the working years would be less costly to the public than tax-supported public relief for health care."

She noted that the bill carries "important safeguards" to prevent over-utilization and abuse of facilities, since persons cannot receive hospital or home nursing care unless so ordered by a physician and a utilization committee would have to pass on any extended stay.

Miss Thompson said that nurses, as well as many others in our society, have a need for this kind of security.

She noted, for example, that staff nurses in voluntary hospitals, comprising over 60 per cent of the total employed, have an average annual salary of $3800 scarcely adequate to "meet all of the exigencies of their retirement, particularly the cost of protracted or catastrophic illness . . . or the long illnesses of dependents."

The ANA representative said that state nurses associations have supported enabling legislation to carry out the Kerr-Mills Act passed in 1960 and have worked with agencies to help develop a sound program. "However," she said, "they are acutely aware that this statute leaves a large gap in meeting the problem of providing health services to our retired population."

The ANA requested editorial amendments that would more clearly delineate responsibilities of the physician, professional nurse, and practical nurse, pointing out that each "has distinct responsibilities and their functions are not interchangeable."

Stating that "in some so-called nursing homes there is little medical supervision and no skilled nursing care," Miss Thompson recommended that "any payments from the social security fund be limited to those facilities which provide at least the minimum of professional services." ANA also asked that the legislation specify "at least one professional nurse" be included among groups to set medical policies for skilled nursing homes and home health agencies, because "there are nursing care functions which are independently determined and executed."

Because of pressures on state associations and individual nurses to repudiate the position of ANA, Miss Thompson requested that a summary of ANA action on social security measures be included in the record. This summary documents ANA's interest in voluntary and compulsory prepaid health plans as early as 1936, and recounts the House of Delegates action in 1958 and 1960 on the principle of health insurance for the aged. (A copy of ANA's testimony was sent to each SNA on July 21.)

Washington Notes

Senate Reports Aging Status. The Senate Special Committee on Aging recently issued a report and Chart Book on the "Health and Economic Conditions of the American Aged," and a report of "State Action to Implement Medical Programs for the Aged." Summarizing the volume of statistics presented, Senator McNamara (D., Mich.) chairman of the committee, said some "12 million older men and women will not be protected under any public program of medical care as of January 1962." The survey shows that to date only 10,000 additional aged persons are receiving medical care benefits under the program enacted by Congress last year. Less than half of the population over 65 has any type of hospital insurance, with the percentages dropping even lower for surgical and medical insurance coverage; their insurance premiums are higher than for the younger, working population, and the percentage of their hospital and medical bills paid for by insurance is less than for younger patients. The first two publications are available for 15 cents, and the second report for 35 cents, from the U. S. Government Printing Office.

President Proposes Two New Institutes. In accordance with his health message delivered to Congress on February 9, President Kennedy has asked Congress to establish a National Institute of Child Health and a National Institute of General Medical Sciences, increasing to nine the number of institutes operated by the Public Health Service within the National Institutes of Health. The Institute on Child Health and Human Development would conduct a stepped-up research program into congenital malformations, infant mortality, mental retardation and maternal factors relating to childhood development. The proposed National Institute of General Medical Sciences merely elevates to Institute status the work currently being done under a Public Health Service division. The President expressed the hope in his health message that the two new institutes would contribute to coordinating medical research related to the total life span of the human being.

In related action, the President has asked Congress to appropriate $3,515,000 for a proposed National Environmental Health Center, which, following construction, will probably result in the formation of a new bureau under the Public Health Service.

Three Education Bills Tabled by Rules. The House Rules Committee voted 8 to 7 on July 18

table three education bills, including H. R. 215, to provide construction and scholarship grants for institutions of higher education; H. R. 500, to aid public elementary and secondary schools; and H. R. 7904, to extend and improve the National Defense Education Act. The President, questioned at his press conference of July 19 on White House strategy in the face of the Rules defeat said, he was "hopeful" procedures to bring measures to the House floor over the Rules Committee's opposition would be used. He referred to the school-aid bill as "probably the most important piece of domestic legislation." One procedure for by-passing Rules is to get 218 House members to sign a discharge petition. Another method may be to have the chairman of House Education and Labor Committee introduce the measure on "calendar Wednesday," but action must be completed before adjournment for that day, and opponents could "talk the day away."

Community Facilities and Services Bill Reported. H. R. 4998, "to assist in expanding and improving community facilities and services for the health care of aged and other persons," was reported by the House Rules Committee and allotted two hours for floor debate. The printed record of hearings held earlier this year, including AMA's testimony, is not available from the House Interstate and Foreign Commerce Committee.

Water Pollution and Housing Enacted. The President signed, on June 30, the Housing Act of 1961, including a $120 million fund to provide loans of $30 million a year for the next four years for hospital housing for interns and nursing students. For the first time, the legislation includes provision for middle-income families to receive low-interest 40-year mortgages with 3 percent down payment. The bill also includes monies for urban renewal projects including hospital expansion, loan authorization for housing for the elderly, and authorization for 100,000 units of public housing.

On July 20, the President signed the anti–water pollution bill to help communities construct sewage-treatment plants and increasing the federal matching grants to states for the administration of water pollution–control programs. This program was extended to June 30, 1968. Under the anti-pollution law passed in 1956, federal clean-up projects have involved 131 cities and 220 industries. States, however, will have to put up $7 for every $3 in federal funds, and the Governor of a state must approve any action to prevent pollution.

Commemorative Stamp to Honor Nursing. "A multi-colored commemorative stamp honoring the nursing profession" will be among a total of fifteen commemorative stamp issues for the year 1961, according to a Philatelic Release from the Post Office Department. The stamp will be issued in late 1961, and first-day ceremonies, to be attended by high-ranking government officials and nurse leaders, will be co-sponsored by the Post Office and Health, Education, and Welfare Departments in Washington, D. C.

Commissions Requested for Men Nurses. On July 13, 1961, Representative Frances P. Bolton (R., Ohio) introduced H. R. 8135, to amend Title 10 of the U. S. Code to permit men nurses to receive commissions in the Regular Army, Navy and Air Force. Following legislation enacted in 1957, men nurses became eligible for commissions in the Reserve Nurse Corps of the Army, Navy and Air Force. The Code establishing the Air Force Nurse Corps already included male nurses in their regular commissioned Corps. The Army, however, still commissions male nurses in the Reserve Corps, and the Navy has not admitted them to date.

Regulations on Hazardous Substances Labeling Act. Warning . . . . Caution . . . . Danger . . . . are signal words soon to be seen on the labels of the hazardous products used in every American home. The 1927 Caustic Poison Act, which required poison labels on only 12 caustic and corrosive substances, has *not* kept pace with the parade of products . . . toxic, caustic and flammable . . . seen with growing frequency on market shelves. The great variety of cleaners, polishes, waxes, detergents, and specialty chemical products, although toxic in nature, were not disagreeable in appearance or odor, and many physicians became alarmed at the frequent injuries, often tragic, resulting from the accidental use of these products. Sometimes the container of the offending product was available but gave the physician no information as to its contents which would have made quick first aid treatment possible. Delay sometimes meant the difference between life and death. The U. S. Public Health Service estimates that every year some 600,000 children swallow household aids and that about 500 children die as a result.

Therefore, the medical profession, the Food and Drug Administration, and many responsible officials of chemical and manufacturing firms recognized that a stronger Federal law was needed. The 1927 law was as outmoded as the bustle and much less useful!! Quite literally, today's "living" requires more comprehensive labeling . . . hence the new Federal Hazardous Substances Labeling Act was passed last July.

Simply stated, this consumer protective legislation will require of the manufacturer more rigid labeling, and labeling of many more products than were covered by the old law. It stipulates

that the danger warning be conspicuously and prominently displayed. The label must carry a clearly-understood statement of the precise hazard of that product, the precautionary measures to be followed, practices to be avoided in its use, and instructions for first aid treatment. The word "POISON" for any highly toxic substance must be shown and if the product requires special handling or storage, this information must appear along with the statement "KEEP OUT OF THE REACH OF THE CHILDREN," or equivalent. These requirements are somewhat rigid but Congress believed them necessary.

The above statement describes briefly the proposed regulations developed by the officials of the Food and Drug Administration for the administration of a new law, The Federal Hazardous Substances Labeling Act, which went into effect on August 1.

All regulations are printed in the *Federal Register* after promulgated so that individuals and groups may comment on them. In this instance, although the industries affected helped to promote the legislation, they are now objecting to the regulations declaring that they are too rigid and will interfere with sales.

The regulations were drafted with the sole aim of carrying out the intent of the law and for protecting the public. To date, the consumer and user of hazardous substances has registered no comment. Support for the Food and Drug Administration in the carrying out of the law, with regulations it believes are essential to effective control, will assure the public the degree of protection which the law was enacted to achieve.

AMA Officials Disagree on Federal Drug Role. Senator Kefauver's (D., Tenn.) Senate Judiciary, Antitrust and Monopoly Subcommittee, holding hearings on S. 1552, to increase federal regulation of the drug industry, heard opposing testimony from AMA witnesses. Dr. Hugh H. Hussey, Jr., chairman of the AMA's Board of Trustees, outlined the AMA information program on drugs, and expressed the opinion that changes would come only through voluntary action by the AMA, the drug industry and individual physicians. He particularly objected to a provision that would require the FDA to rule on the effectiveness of new drugs, as well as safety, claiming this could only be judged by doctors. Senator Kefauver argued that federal certification of the efficacy of drugs would protect the public from useless products and misleading advertising.

Two members of the AMA's Council on Drugs testified in favor of the legislation, and questioned the AMA's opposition to the bill's testing provisions when the 14-member Council on Drugs had never been consulted by the AMA leadership. Dr. Louis S. Goodman, Chairman of the Department of Pharmacology at the University of Utah College of Medicine, said the AMA's opposition was unwise and not in the best interests of the medical profession or the public's health. Dr. Charles D. May, professor of pediatrics at New York University Medical Center, said a "substantial proportion" of direct mailings and ads in medical journals aimed at doctors contain incomplete and inadequate information, and that it was wrong to assume that individual doctors can evaluate each drug's usefulness. He said the drug industry's promotion of "unwarranted" products and its promotional activities may subject patients to "illogical and excessive" use of drugs.

Dr. Allan Butler, Chief of Children's Medical Service, Massachusetts General Hospital, professor of pediatrics at Harvard Medical School and President of Physicians Forum, one of 11 medical authorities appearing in favor of the legislation, said the AMA, in opposing the bill's proposal to require proof of efficacy and safety before a new drug may be marketed, "certainly does not speak for the many thousands of physicians who are daily confronted with the obstacle of the excessive cost of the therapy their patients need, irresponsible public advertising and sensational and misleading promotional material addressed to physicians."

Kefauver's bill would require federal licensing of all drug manufacturing companies to ensure "the chemical structure, strength, quality, purity, safety and efficacy of drugs;" requires the Secretary of HEW to establish future generic drug names; requires that the generic name be displayed as prominently and in the same size print as the trade name in any labeling or advertising; empowers the FDA to check drugs for efficacy as well as safety; limits exclusive rights to a new discovery to the first three years of the patent; limits patents on drug modifications to those HEW determines will significantly enhance the therapeutic effect; and would make illegal the allotting and restricting of patents by private agreement among competing firms.

In issuing Report N. 448 on last year's investigation of drug prices, which was the basis for this legislation, Senator Kefauver said profits were "astonishing" and warned, "Unless this measure or something closely resembling it is adopted the American people, whose patience with price-gouging in drugs is wearing thin, will demand that their government adopt the tougher approach of direct governmental controls." A single copy of the report is available from the Senate Judiciary, Antitrust and Monopoly Subcommittee, and additional copies may be purchased from the Government Printing Office for $1.00.

Book Reviews

Oakes' Dictionary for Nurses

By Nancy Roper, S.R.N., R.S.C.N., S.T.D., 492 pp., $2.75, E. & S. Livingstone Ltd., 1961.

British spelling and style, but conveniently small, and modestly priced.

Elementary Textbook of Anatomy and Physiology

By Janet T. E. Riddle, 128 pp., $3.50, Williams & Wilkins, 1961.

This book is based on lectures given to nurses at Killearn Hospital. The presentation is done in a very simple manner and limited definitions and explanations are given. The book would not be too usable here where anatomy and physiology are more integrated into the entire curriculum. The 124 pages give what I would consider a very sketchy outline of anatomy and physiology as applied to nursing.

ROSE ANN POYZER, R.N.

District Nursing

By Eleanor J. Merry, 306 pp., $6.00, Williams & Wilkins, 1960.

This book is designed as a manual for student district nurses and a reference book for practicing district nurses in England. It gives an over-all picture of services available to their patients. Presentation of material is given in very simple terms. The benefits of this book for nurses here are limited. It does give a good format of their situation but would be applicable only on a comparison basis for nurses here.

The historical background of district nurses in England is well done and is of value in this area for nurses here.

ROSE ANN POYZER, R.N.

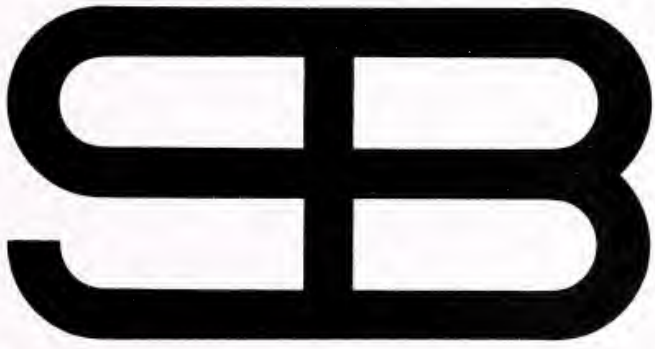
Medicine for Nurses

By M. Toohey, M.D., M.R.C.P. DC.H, 667 pp., illus., $7.00, Williams & Wilkins Co., 1960.

A comprehensive textbook of medicine written for student nurses in basic nursing programs and for graduate nurses as a reference text. The discussion of various diseases is outlined in a clear, readily understood manner. Photographs and useful illustrative diagrams emphasize the important facts of pathology and medical treatment. A summary of drugs and routine procedures is included after each major disease. Summaries of the more difficult chapters are included to stress the important facts. In addition, a chapter on psychosomatic medicine is included to help the beginning student develop an awareness of the psychological development of the individual from infancy. It further undertakes a discussion of neuroses types and their treatment, as well as the role of the nurse in psychosomatic medicine in appreciating the emotional and psychological needs of the individual.

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

BERYL UYEHARA, *Editor* MAX BOWMAN, *Associate Editor*

ASMT Post-Convention in Hawaii

The Hawaii Extension of the 29th annual ASMT convention is now history, an accomplished fact. Lest we forget too soon, a few words of appreciation and commendation will be accorded here to the Hawaii technologists who organized and carried the program through from inception to successful conclusion. It took talent, time, and much hard work; chairmen Ann Stegmaier, Grace Kagawa, Alice Tonchen, Masaji Nakagawa, and their lieutenants are to be congratulated for an excellent job. One indication of the "post" session's success is the enthusiasm of mainland technologists for a repeat performance in five years.

The Extension was held June 18-23 at the Hawaiian Village Hotel. One hundred and thirty mainland technologists and 50 local members attended the various events. A blood-bank workshop and a lecture on PBI and steroid chemistry were held for HSMT members. There was an airport reception with homemade leis for all visitors.

After the invocation by Rev. Paul Nagano and the welcoming address by Lt. Gov. James K. Kealoha, the assemblage was greeted by officers of ASMT and HSMT. Dr. Harold Civin spoke on "Medical Technology Educational Program in Hawaii." Other speakers were Drs. I. L. Tilden, who gave the keynote address, Paul Tamura, Edwin Chung Hoon, Walter B. Quisenberry, Max Levine, and George Chu. Social events included a luau on Wednesday evening and the official dinner on Friday when Dr. Nils P. Larsen spoke on the practice of medicine in old Hawaii. Tours were planned to visit orchid collections, Pearl Harbor, and around the island. Many of the visitors stayed over for the neighbor island excursions.

CAROLYN J. MCCUE, HSMT

*Venous Coagulation Time**

Two-syringe–Two-tube Silicone Technique

One of the great fallacies in blood coagulation work is the belief that the technique of collection of the blood sample will not affect the results. The fact that a poor venipuncture will not normally affect other blood studies has led many workers to believe the same would apply to coagulation. No belief could be more erroneous.

When venous blood is introduced into glass tubes, the time required for clotting to occur is called the coagulation time or clotting time. This is an arbitrary procedure, since the glass surface and many other factors affect the coagulation time. It must be remembered that this result is purely relative, and the method is of value as a screening procedure in an effort to determine plasma coagulation defects and anticoagulant activity.

The two-syringe, two-tube silicone technique has completely replaced the conventional Lee-White method at Ellis Hospital. It is more time-consuming, but it has proved to be far more accurate, and will show the presence of any defects that might be present in the coagulation system.

The materials needed are two 5 cc syringes, one that has been siliconized, and the other plain, and two tubes, 15 x 55mm. One of these must be siliconized and the other plain. G E dri-film, SC-87, is the only silicone that has given suitable and reproducible results for us.

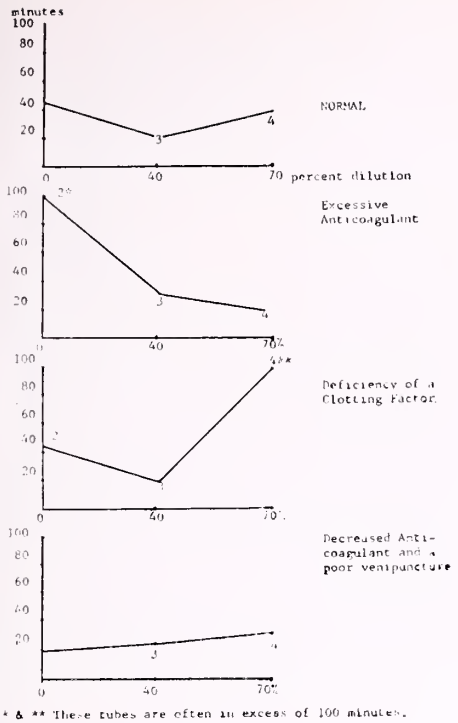
A clean venipuncture is a necessity. A 19 gauge needle is preferred for its size and speed; a 20 gauge is acceptable in children. No smaller gauge should be used.

Using the plain glass syringe, approximately 5 cc of blood is withdrawn, and discarded, or used for other examinations. Immediately attach the siliconized syringe and withdraw 5 cc of blood. From this syringe place 1 cc in the plain tube and 1 cc in the siliconized tube. Time is started from the moment all the blood has entered the siliconized syringe, not when it first enters.

As soon as possible, place the tubes into a 37° water bath. After 5 minutes tilt the plain glass tube. If coagulation has not begun, then wait 3 minutes and tilt again. As soon as coagulation nears its end point, tilt every minute, and finally every 30 seconds until a solid clot permitting complete inversion of tube is obtained.

The siliconized tube should not be touched for 15 minutes, then every 5 minutes until the process becomes apparent; thereafter every 3 min-

* Obtained from *The Journal of the Empire State Association of Medical Technologists.*



* & ** These tubes are often in excess of 100 minutes.

utes, and finally every 1 minute, until the process is complete. Because of the siliconized surface, the clot may not adhere to the wall of the tube, and complete inversion may not be possible. A complete solid clot is readily apparent, however.

The normals for this Coagulation Test are as follows:

Plain Glass Tube	10-20 minutes
Siliconized Tube	25-45 minutes

These normals are for 37°, not for room temperature, and were established at this institution.

Accuracy and technique are very important. A poor venipuncture will markedly hasten the coagulation process, as will sudden jarring of the tubes. Any defect in the coagulation system will show itself in the siliconized tube, whereas a normal time might be found in the glass tube.

Should an abnormal time be obtained with the siliconized tube, then further studies should follow. However, a finer procedure involving four tubes with two saline dilutions of 40% and 70% is very effective as a further screening method, to determine what further tests might be performed.

With this method, four tubes are numbered 1 through 4. No. 1 is a plain glass tube, No. 2 is a siliconized tube, No. 3 is a siliconized tube with 0.4 cc of saline added, and No. 4 is a siliconized tube with 0.7 cc of saline added.

The usual procedure is followed for obtaining the blood. Into tubes 1 and 2, place 1 cc of blood from the siliconized syringe. Into tube 3, place 0.6 cc of blood, and into tube 4, place 0.3 cc of blood.

All tubes are placed at 37° and the usual procedure is followed as for the two-tube method, with one exception. When one tube is tilted to examine for coagulation, then tilting of the other tubes must follow immediately. This is obvious, since all must be handled in the same manner for exacting and reproducible results. The examples that are shown on the graph, illustrate what might be expected for the types most often encountered; The Normal, The Excessive Anticoagulant; Deficiency of a Clotting Factor: Decreased Anticoagulant; and a Poor Venipuncture.

A poor venipuncture will produce virtually the same coagulation time in glass and siliconized tube, and would, therefore, abolish the dilution effect. Poor siliconizing of the tubes will also produce similar errors. In each of the examples the No. 1 tubes are omitted as the siliconized tubes will be the ones to show significant changes.

DONALD HESS, M.T. (ASCP)
Ellis Hospital, Schenectady

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HAWAII MEDICAL ASSOCIATION

(Continued from page 60)

to individual states, with the general guide that physicians may ethically associate with osteopaths who practice medicine, but not with osteopaths who uphold and practice the basic tenet of osteopathy, the musculoskeletal lesion.

SURGICAL FEES

Surgical fees may ethically be charged for bona fide service rendered, but *not* for mere referral to a surgeon, or for *pro forma* presence at an operation. A surgeon may employ one or more assistants and pay them, even for a single particular case. Under other circumstances, each physician involved in the care of a patient should submit his own bill for services rendered.

GENERAL PRACTICE RESIDENCIES

There is little agreement as to whether these save patients' lives or endanger them, but additional two-year programs incorporating experience in obstetrics and surgery were endorsed by the House.

POLIO VACCINATION

A Council on Drugs report, now in press, urges continuation of Salk vaccine now, and a switch to Sabin vaccine, said to be more effective at reducing the actual incidence of polio (nonparalytic as well as paralytic) as soon as it becomes available. Salk was indignant, via Western Union.

INCREASED DUES

AMA dues go up to $35 in 1962 and to $45 in 1963, for specific purposes. There was only one dissenting vote.

AWARDS

Walter H. Judd, physician and congressman, received the Distinguished Service Award. The General Practitioner of the Year award was abolished.

SOCIAL SECURITY

Father still knows best: no Social Security for doctors unless they can figure out how to get it on their own, which an estimated 40% have done.

PORTLAND, NOT LAS VEGAS

In December, 1963, Portland, Oregon, will be the AMA's meeting place. The Board of Trustees and the Reference Committee on Reports of the Board of Trustees both recommended Las Vegas, but cooler heads in the House prevailed, and the famous playground was shelved for a more sober site.

PHARMACEUTICALS

The House opposed pending legislation to authorize the Food & Drug Administration to pass on the efficacy and safety of new drugs prior to their release, and reaffirmed their opposition to compulsory prescription or sale of drugs by generic name only.

George M. Fister of Utah, whose term on the Board of Trustees was to expire next year, was chosen President-elect over Julian P. Price of South Carolina, Chairman of the Board, whose term as Trustee had just expired.

Hugh Hussey of the District of Columbia, first active Dean (of Georgetown University Medical School) to be an AMA Trustee, is the Board's new Chairman.

Norman Welch (Massachusetts) and Milton Rouse (Texas) were re-elected to the Speakership the Vice-Speakership respectively.

NEXT MEETINGS

The AMA will meet in Denver, November 27-30, 1961; Chicago, June 11-15, 1962; in Atlantic City in 1963, and in San Francisco in 1964.

HARRY L. ARNOLD, JR., M.D.
Delegate

RICHARD D. MOORE, M.D.
Alternate Delegate and Delegate-elect

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NOTES AND NEWS

(Continued from page 61)

Dr. Thomas Chang for the first hole in one on the new No. 2 hole at the Waialae Country Club.

The Blood Bank of Hawaii, which celebrated 20 years of community service in June. The medical profession should be mighty proud of the great job **Dr. F. J. Pinkerton** and **Dr. Leon E. Mermod** have done and are still doing.

Dr. Robert B. Faus, father of the year (medical-dental service), honored by the community at a luncheon on Father's Day at the Princess Kaiulani Hotel.

Dr. Harry L. Arnold, Jr., elected to a three-year term as Secretary of the A.M.A. Section on Dermatology.

Dr. Scott Brainard, who finally succumbed and took Ruth Ann Warner as his bride. **Drs. Gebauer, Hanley, Chu,** and colleagues from the Medical Group lent a helping hand at the wedding.

Dr. Richard Ando, installed in August as the President of the Hawaii Parliamentary Law Association.

New Affiliations and Locations

Dr. Yonemichi Miyashiro, G.P., will do country practice at Wahiawa. His office is located at 960 Center Street.

The Ala Moana group appears to make good prophets out of our local medical men. True to predictions, we note **Dr. Cesar B. De Jesus** opened his office for solo practice at the Waikiki Medical Building, and **Dr. Mor J. McCarthy** joined the surgery department at Straub Clinic.

Also newsworthy was the quiet opening of the Waianae Clinic at 87-217 St. John's Road.

Dr. Philip W. H. Chock has moved to 45-1026 Kam Hiway, Kaneohe.

Dr. Henry A. L. Yim, pediatrician, has also opened in Kaneohe, at 45-939 Kam Hiway.

Dr. Richard T. Mamiya, surgeon, is now associated with the Central Medical Clinic.

Mr. R. M. Kennedy, HCMS executive secretary, is resigning from his position and will affiliate with Straub Clinic as its Clinic Manager. Good luck, Dick!

Dr. Takeo Fujii has moved back to his old office at 1914 South King.

Drs. Grover Batten and **Thomas Bennett** are now sharing office space on the second floor of the Alexander Young Building.

Dr. Francis M. Terada has joined the ob-gyn department of The Medical Group.

Dr. Michael M. Okihiro, neurologist, is now with the Straub Clinic.

Hawaii Doctors in Print

Dr. Herbert G. Pang wrote an article on "Surgical Formation of Upper Lid Fold" which appeared in the *Archives of Ophthalmology* June, 1961. **Dr. Joseph E. Strode's** article on "Malignant Lesions of the Stomach in Hawaii: Experiences with 350 Patients" appeared in the May, 1961, issue of *Surgery*.

Travel News

Dr. M. H. Lichter just returned from Jerusalem. He attended a clinical post-graduate program held by the Hebrew University, Hadassah Medical School in Israel in cooperation with U. C. L. A.

Dr. Donald Brown and family are mainland bound and having a wonderful time.

Ex Medical Group radiologist, **Dr. George Henry,** is cavorting around in Europe.

Dr. Ralph Cloward will visit his children in Europe and then tour the continent.

Dr. Harold F. Moffat attended the 3rd International Conference on Ophthalmology at the Instituto Barra Quar in Spain.

NEWS

Urologists Note

Urology award—$500, $300, and $200 prizes for essays on results of some chemical or laboratory research in urology. Hospital interns and residents are eligible. The deadline is November 15, 1961. For further details, call the HMA offices.

COUNTY SOCIETY REPORTS

(Continued from page 62)

that whatever is decided upon tonight, we must continue to keep the good will of some 200,000 subscribers and also our good public relations with the community.

Dr. Hartwell brought out that at a recent meeting of the officers of the Medical Society with HMSA (held at the latter's request) the officers went beyond the recommendations of the Board of Governors and offered in addition, "either the Medical Committee of HMSA or the Medical Society could, without consultation of the other and within 30 days, drop a participating physician without cause." The Chair then stated that there will be a meeting of the Board of Directors of HMSA next Thursday (called at the request of two physician members of the Board) to discuss the termination of the contract and that it would be a great help to our medical men on that Board if they knew the membership was willing to back up the officers in the above recommendation. Following a brief discussion it was moved, seconded and passed that the recommendation be approved.

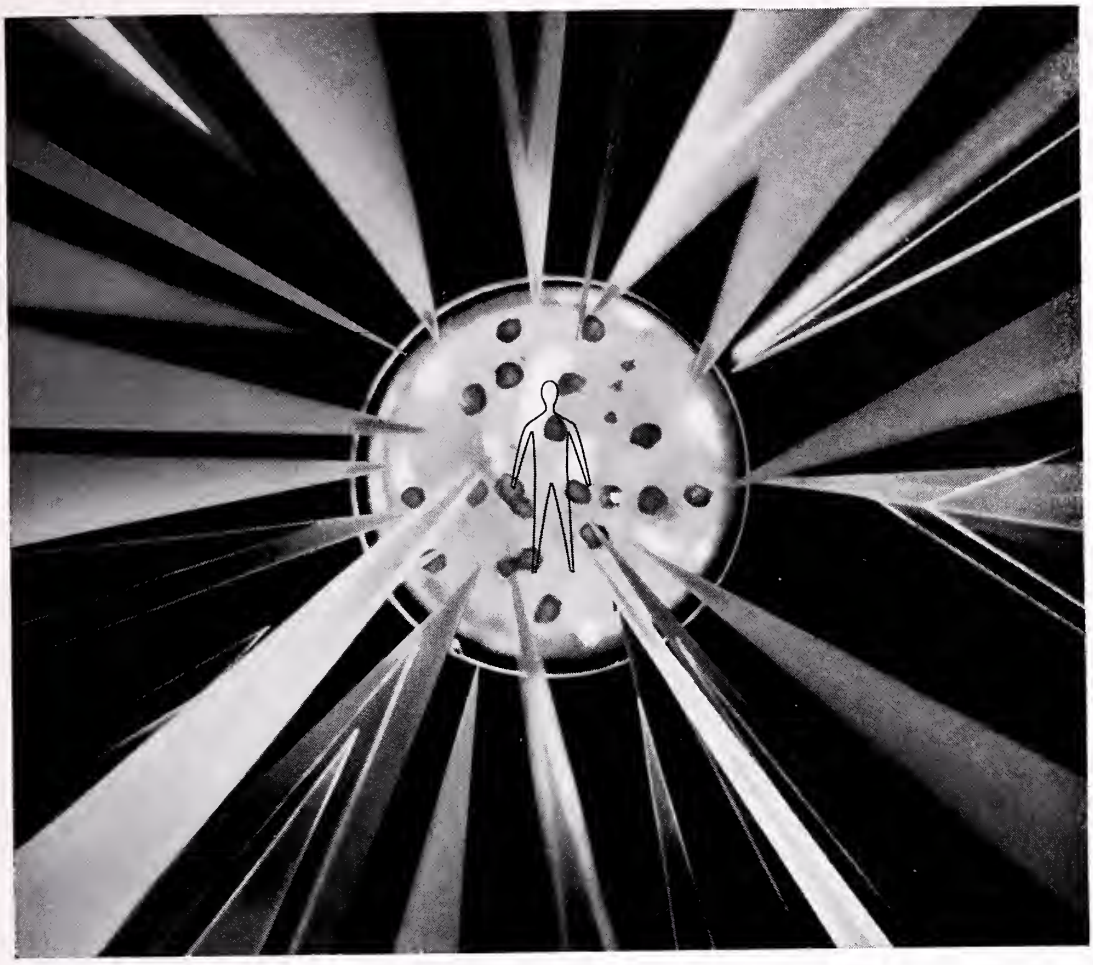
The Chair went on to state that the officers would also like to include in their instructions to the physician members on the Board of Directors the following suggestions as to what we should approach HMSA with:

1. There will be a master contract with each county society including essentially the same provisions as at present.
2. There will be individual contracts with each county society and these contracts will be renewable annually.
   a. The individual contracts will have a 30-day cancellation clause and may be exercised by the physician, HMSA, or the county society.
   b. The Medical Committee of HMSA shall have the final say on the part of HMSA as to the approval, disapproval, or cancellation of a participating physician's agreement.
3. There will be no individual contracts directly with the HMSA for special plans of the HMSA without the approval of the county society involved.

A lengthy discussion followed on whether the Society should accept HMSA's termination of the contract and whether or not the physicians should sign individual contracts with HMSA. The members present expressed their opinions freely and asked many questions.

Following a full discussion on all aspects of the problem, it was the concensus of the members present that the Society accept the cancellation of the present contract with HMSA and that each member of this Society refrain from signing a participating contract directly with HMSA until our negotiating committee gives its report. The following actions were then taken:

(Continued on page 78)



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COUNTY SOCIETY REPORTS

(Continued from page 76)

Dr. Nance moved that this Society request its members not to sign individual contracts with HMSA until such time our negotiating committee gives its report. The motion was seconded and was carried.

Dr. Fujiwara moved that the County Medical Society give our president and the officers who are negotiating in this matter our support of confidence. The motion was seconded and was carried.

Dr. Ando moved that the preliminary recommendations to our member physicians on the HMSA Board of Directors as mentioned by Dr. Hartwell be the action of the Society and that the president, the officers and representatives be instructed to work to that objective. The motion was seconded but failed to carry.

Constitution and Bylaws:

The Chair suggested that because of the late hour that the approval of the proposed amended bylaws be postponed until the next membership meeting which will be held on July 11, 1961.

Dr. Ando then read a preliminary report of the Bylaws Committee and moved that the bylaws as circulated be considered as read throughout at tonight's meeting. The motion was seconded and was carried.

Fee Schedule Changes:

The following changes and additions were approved by the membership:

TYMPANOPLASTY:

5992	Tympanoplasty (Type I) (Myringoplasty) uncomplicated	60.0	30 days
5993	complicated, including change in contours of external bony canal and/or combined with middle ear surgery, post-auricular or endaural approach	90.0	30 days
5994	Tympanoplasty (Myringoplasty) (Types II through IV)	110.0	30 days
5995	Tympanoplasty (Tympanoplasty) (Type V), two (2) stages	110.0 +20	30 days

OPEN HEART SURGERY:

A. Repair, inter-atrial septal defect ..... 440.
B. Repair, inter-ventricular septal defect ..... 540.
C. Tetralogy of Fallot or multiple defect, open operation ..... 640.

Relative values for members of the team on the basis of their value to the team are as follows:

	%	UNITS	A	B	C
Surgeon	30%	133.3	135.	170.	200.
Ass't. Surgeon (not more than 2 to be paid)	7½%	33.3	30.	35.	40.
Ass't. Surgeon	7½%	33.3	30.	35.	40.
Anesthesiologist	15%	66.7	65.	80.	95.
Pump Operator	15%	66.7	65.	89.	95.
Cardiologist	25%	111.1	115.	140.	170.
			440.	540.	640.

The meeting adjourned at 11:15 P.M.

R. D. MOORE, M.D.
Secretary

Kauai

A regular meeting of the Kauai County Medical Society was held June 6, 1961, at Wilcox Hospital Library. The meeting was called to order at 7:30 P.M. by the President. Dr. Kim was appointed as Secretary, pro tem, in absence of Dr. Goodhue.

Dr. Walter B. Herter's application for membership was approved.

A letter from Mr. Hector Moir dated May 19, 1961, was read. Its content touched on aerial spraying of herbicide, on smoke and fumes from adjacent areas near their home and garden. It was moved, seconded and carried that the letter be referred to proper authorities in the State Health Department and that Mr. Moir be so advised.

Dr. Wade, HMA Delegate, reported on the recent meeting held in Honolulu. He pointed out the resume was sent out in the Newsletter. He noted that the new dues will be $60 per year. He also informed the members that the House of Delegates approved that for members to be in good standing with the local Society, they shall be members of the AMA, to be effective January, 1962.

After discussion on AMA-County membership status, it was moved and seconded that the Society disapprove of this action by the House of Delegates. The vote was 2 for and 5 against this motion.

Dr. Wade also pointed out the need for local Society's Constitution and Bylaws to be revised to conform to the HMA Constitution and Bylaws. No action taken.

The individual contracts with HMSA were discussed at length. It was finally moved, seconded and carried that the Society's HSMA delegate, or its representative, convey to the HMSA (1) that the members do not approve the manner in which the HMSA Executive Committee abruptly cancelled the contract with this Society without prior negotiations, and (2) that this problem of the participating physician's agreement with the HMSA be referred to the Hawaii Medical Association with the suggestion that it be handled on a State level.

Dr. Boido informed members on the progress of the negotiation of the fee schedule with the County Board of Supervisors. Members were advised that the County was waiting for the Legislature to end. He also informed the Society on the radio program sponsored by Pfizer and was advised that the radio station would only want members to answer questions asked by the people.

The meeting ended with Dr. John Dillon, Professor of Anesthesia at UCLA, giving an interesting talk on Myasthenia gravis and the effect of various anesthetic agents.

PETER KIM, M.D.
Secretary, Pro Tem

* * *

A special meeting of the Kauai County Medical Society was called to order by Dr. P. M. Cockett, President, at 7:30 P.M. at the Wilcox Hospital in Lihue, Kauai, on June 27, 1961. Guest speakers were Dr. George Mills and Dr. Morton Berk of Honolulu who discussed the Hawaii Foundation Medical Plan.

Meeting adjourned at 9:40 P.M.

* * *

A special dinner meeting was held at the Kauai Inn on July 7, 1961, with Dr. P. M. Cockett presiding. Guest speaker was Dr. Harry J. Alvis, Captain, Medical Corps, U. S. Navy, Submarine Base, Pearl Harbor, Oahu, who spoke on the hazards of diving or depth exposure. Other guests were Dr. Tien and Dr. Salazar. Mr. and Mrs. Bruce Mitchell of the G. N. Wilcox Hospital Anesthesia Department were also present as guests.

Following a very interesting talk by Dr. Alvis, the regular meeting of the Society was held. The minutes of the previous meeting were accepted as circulated. The Treasurer gave his financial report, noting that there was a balance of $65.36. It was moved by Dr. Boido and seconded by Dr. Kim that a $10.00 assessment be made. This was carried.

W. W. GOODHUE, M.D.
Secretary-Treasurer

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HAWAII MEDICAL ASSOCIATION

(Continued from page 60)

was noted that podiatrists have been allowed to work at St. Francis and Queen's. The question came up as to just what the hospitals permit them to do.

ACTION:

A motion to table any action on this until information is received from AMA and their new commission as well as from the local orthopedic society was seconded and passed.

PUBLICATIONS COMMITTEE

One request for exchange and one for a free subscription were submitted to the Council.

ACTION:

A motion to approve these requests if the editor of the JOURNAL feels this would be of value was seconded and passed.

REPORT OF THE SECRETARY

The Secretary reported that since the last Council meeting the following new members have been reported: March (Honolulu) Florence Chinn; April (Honolulu) Jeanette Chang, Samuel Clark, Robert C. Lee, Joseph C. Finney (transfer from Associate to Active); May (Honolulu) John F. Hanley, Doris Jasinski, Robert A. Nordyke, George F. Parker; June (Honolulu) Charles T. H. Ching, Mor J. McCarthy, (Kauai) Walter B. Herter (transfer from Honolulu). Deletions from the Honolulu roster were (April) Kenneth Amlin; (May) Donald Depp and M. E. Johnson; (June) Kenneth Ching. Total membership figures were 617 for March, 622 for May, and 625 for June.

ACTION:

A motion to approve the Secretary's Report was seconded and passed.

TREASURER'S REPORT

An accounting of the expenditures for the first six months was circulated. Dr. Richert summarized the transactions for the period and asked if there were any questions. It was noted that the Golf Committee deficit had been reduced from $231.50 to $129.59. Dr. Richert called attention to his suggestion that there be two signatures on all Association checks.

ACTION:

A motion to require two signatures on all checks, one of which must be either the Secretary's or Treasurer's and the other the executive secretary's or that of an officer, was seconded and passed.

A motion to accept the Treasurer's Report was seconded and passed.

PR REPORT

Mr. Lytle reported on some of the activities of the PR Committee in relation to the formation of the Honolulu Foundation, the Speaker's Bureau, the activation of the Hawaii Physicians' League for Good Government, the early distribution of material for next year's AAPS Essay Contest, the cooperation of the radio stations in giving public service time, the formation of Dr. Caver's Health Museum, the continuation of TV programs under the auspices of the Health Education Committee, the addition of the 12-program series on KAIM featuring a series of short programs entitled "Highroad to Health," and the suggestion of annual awards for outstanding medical reporting. Dr. Allison felt that the Health Education and the Public Relations committee activities should be kept separate in order that the free time made available to the Health Education Committee would not be jeopardized. However, the two committees should work closely together. After it was learned that newspapermen from all islands belong to the Press Club, it was agreed that a cash award and the presentation of a perpetual trophy should be made annually at the Gridiron Dinner.

Mr. Lytle made an announcement of the Tenth Pacific Science Congress and asked that he be given permission to devote five full days to working with this group just prior to his departure for Chicago.

ACTION:

The motion to permit Mr. Lytle to devote five full days to the Science Congress was seconded and passed.

AMA DELEGATE'S REPORT

Dr. Arnold made a preliminary report on his last AMA Annual Meeting, giving some highlights and asking the Association to give his successor, Dr. Richard D. Moore, instructions if there were any objections to the bylaw change which would give the AMA original jurisdiction in disciplinary matters. Mr. Kennedy said this is contrary to the HCMS bylaws. The members of the Council agreed with the new concept and Dr. West pointed out that under the revised HMA bylaws the Council may take action in excess of that taken by a county's disciplinary board.

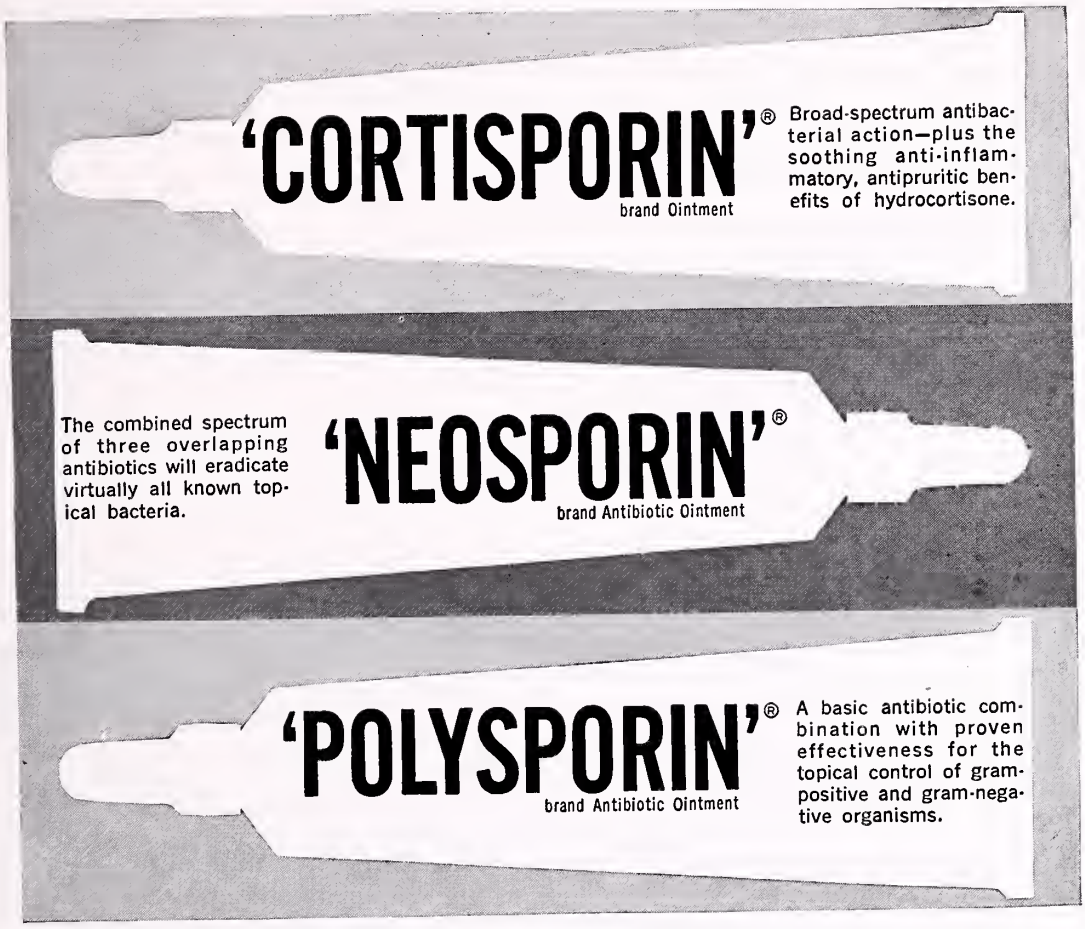
HMSA RELATIONSHIP

Dr. Burden explained that the date of the Council meeting was changed to enable the councillors, who are now voting members of the House of Delegates, to attend both meetings on the same day. The sole purpose of the House of Delegates' meeting is to discuss the HMSA problem. Dr. Burden advised that the request for a special House of Delegates meeting was made after the HMSA county contracts were canceled. Most of the uproar was based on the way this was done. There is a feeling on the part of many that it removes the proper controls over the policy making and fee control portions of the HMSA program. He said that by requesting the House of Delegates to meet and take up this problem, the matter was thrown into the state Association's jurisdiction, more or less. However the HCMS, after their president came back from his vacation, decided they should take action themselves and they have advised that negotiations with the HMSA for a master contract are proceeding and it looks like the problem is about to be resolved.

Dr. Giles said that in view of the success of the negotiations going on at the present, he felt that the Council could not recommend to the Delegates at the present time that this be on a state level. Since the relationship has been on a county basis for a considerable length of time, we could do harm if we were to change it now. However, he thought that the state should make future negotiations with HMSA. He thought we should recommend that the negotiations be carried on as they are at present. The HCMS has been authorized to negotiate for the other counties and this should be continued. However, in the future, clarification should be made as to what the problem is. It may be possible to convince HCMS that this should be carried on at a state level, but no agreement can be made until they are given a proper proportion of the members of the committee involved.

(Continued on page 84)

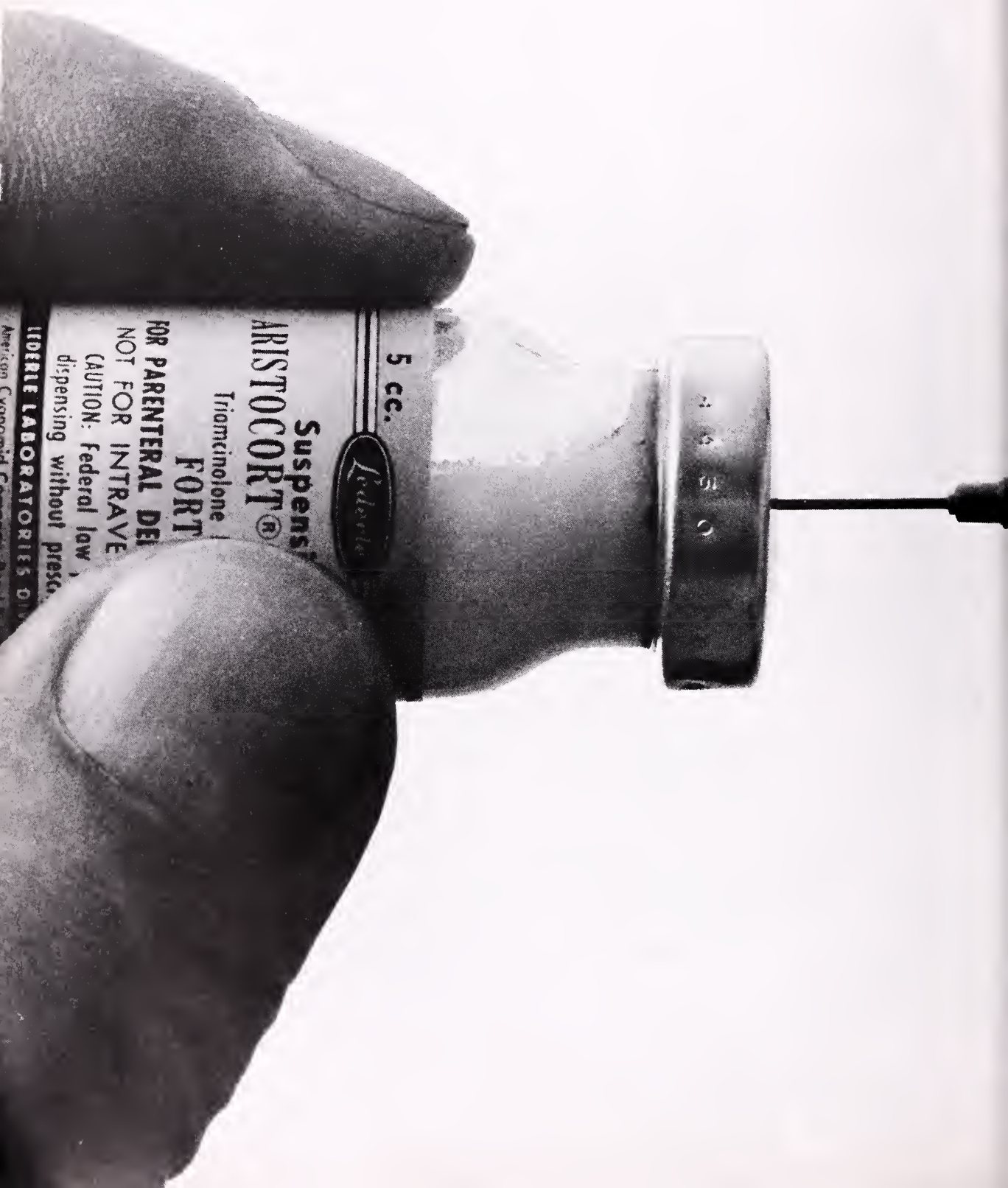
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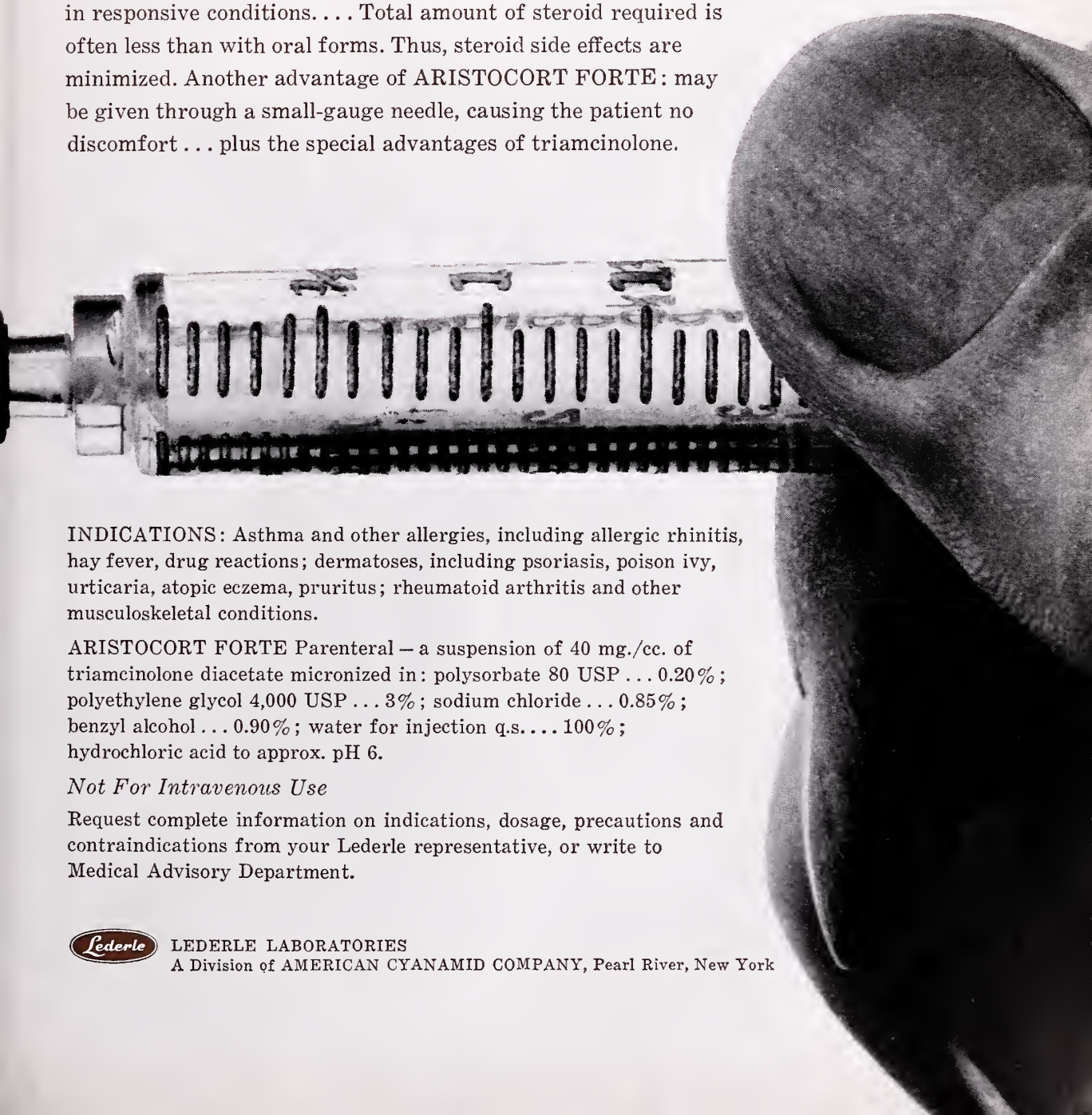
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HAWAII MEDICAL ASSOCIATION

(Continued from page 80)

Mr. Kennedy said that in the negotiation of this contract at a county level, Honolulu county has never thought it was speaking for any other county. He assumed that if the proposed contract is negotiated at the county level, the very same contract will be negotiated with every other county.

The meeting was recessed at this point and reconvened again at 9:00 P.M.

WAIVER OF REGISTRATION FEES

It was noted that the waiver of the registration fees for some of the guest speakers and for a physician from the USPHS, who was advised by one of the members that he would not have to pay, had not been previously granted.

ACTION:

The motion to waive the registration fees for Col. Carl W. Hughes, Drs. Paul McCallin, Wilhelmina Haake, and Thomas McBride was seconded and passed.

BRONZE PLAQUE

It was noted that no progress had been made in developing this project pending permission to use the State of Hawaii seal, which has now been refused.

ACTION:

The motion to refer this back to Dr. Giles and his committee to study further and present to the next meeting was seconded and passed.

DUES

Mr. Kennedy suggested that since the state dues are going up so much next year at the same time as the AMA dues, which will be mandatory, are going up, information regarding these increases should be circulated before the bills go out. HCMS will send out their bills with every item itemized. He was advised that this information had been announced and had been circulated through the newsletter. He thought it would be a good idea to condition the members to expect this bill because he wasn't certain they were aware of the big increase.

ACTION:

The motion to have the public relations counsel determine a good way of advising the membership of the increase in dues was seconded and passed.

The meeting adjourned at 9:10 P.M.

Respectfully submitted,
RODNEY T. WEST, M.D.
Secretary

MINUTES OF THE HOUSE OF DELEGATES MEETING

July 21, 1961, 7:30 p.m.
Mabel Smyth Auditorium

PRESENT

Dr. J. A. Burden, presiding; Drs. Allison, Andrews, Homer Benson, Robert Benson, Berk, Boido, Bruce, Cushnie, Dang, Giles, Goodhue, Hartwell, Ho, Ito, Vernon Jim, Judd, Leong, Lum, Mills, Moran, Nishijima, Richert, Sloan, Vasconcellos, Waite, Wong, and West; Past Presidents Arnold, Jr. and Nishigaya.

The Secretary called the roll, seated four alternate delegates, and announced that there was a quorum present.

The Secretary was asked to read the June 15 letter signed by 20 delegates, which was the basis of calling the special meeting.

We the following delegates of the Hawaii Medical Association request a special meeting at the earliest possible date to discuss any possible relationships with HMSA or any other organizations.

We request that any meetings or negotiations concerning this matter be deferred by our officers until after the special delegates' meeting.

The President explained that in accordance with the Bylaws the meeting had to be limited to the subject matter included in the letter requesting it. He opened the meeting for discussion.

ACTION:

Dr. Leong moved, seconded by Dr. Nishijima, that the state association refrain from any negotiations with the HMSA.

Dr. Arnold suggested that since this was a special meeting, the House of Delegates could not legally take any action except on what it was specifically called for; and since it was called for discussion, he thought only discussion, and no action, could be taken.

Dr. Richert said he did not feel that the motion was in good form because it did not specify any time or make any limitations. Negotiations are going to have to be made with the HMSA, maybe first on a county level, but we hope eventually on a state level. If this is done with individual counties, that is something to be worked out. But he thought it was a mistake to completely close the door to any negotiations on a state level. Dr. Cushnie thought that this type motion is like cutting our own throats. Dr. Richert asked if the maker of the motion would rephrase it. There was no change made in the original motion.

ACTION:

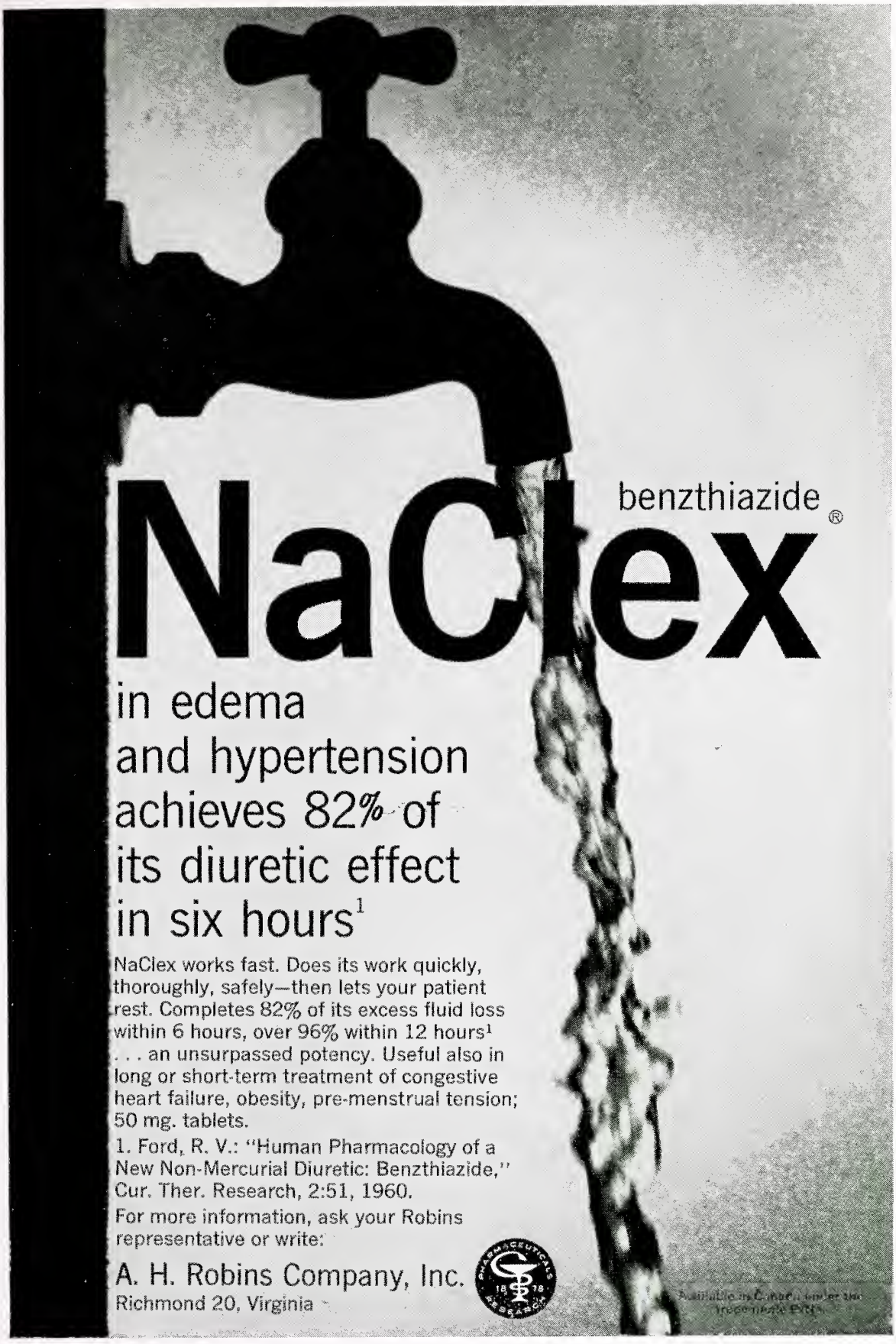
Dr. Richert moved, seconded by Dr. Cushnie, to table the motion until there was more discussion on the subject. The tabling motion passed by a vote of 24 to 2.

The President again asked for discussion and requested the Secretary to reread the letter asking for a special meeting.

Dr. Richert said there are two separate views, as he saw it. The outside islands are perfectly satisfied with HMSA, whereas Honolulu County has not been. The outside islands have not wished to do their own disciplining; here on Oahu the doctors feel they want more teeth in their disciplinary actions. There is a faction which is afraid that HMSA, as a business organization, is trying to take the control away from the doctors. The outside islands have not felt that way. They are willing to divest themselves of the county contract in order to have HMSA take over the disciplining. On the other hand, Honolulu wants to keep their disciplinary powers and have a definite interest in the running of the HMSA, which they felt they would not have without a master contract. He thought we had better stick together on this, and everybody should accept the same contract. We have to stick together in order to have authority with the insurance carrier so that we can have representation on the Board.

Dr. Mills said he didn't think that the reason the HMSA canceled the contract was related to discipline. He felt that the Medical Committee of the HMSA did not represent the medical society. He said that the out-

(Continued on page 86)


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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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HAWAII MEDICAL ASSOCIATION

(Continued from page 84)

side islands were happy to sign individual contracts, but the Medical Committee didn't feel that should be done until something was worked out as to who was going to set fees and how the Fee Adjustment and Medical Care Plans Committee could sit down and decide the terms of the contract.

Dr. Hartwell gave a brief summary of events that had taken place in Honolulu. There was the matter of fees. He noted that some of the fees listed in the 1938 schedule had been changed very little and some doctors felt that economics was the main reason for the difficulties. He commented on the Community Group Plan and the difficulties that arose out of that. The next thing was the coverage for the Federal employees, who probably don't represent such a large segment of the neighbor island doctors' practice as they do on Oahu. The HMSA set up a splinter group to police the Federal employees plan and these men have done an excellent job. But it was a group over which the county society had little or nothing to say. Men from Honolulu County, at county expense, went to Washington to discuss this plan before it went into operation, but they were not on the negotiating team. There seemed to be a breakdown of relations. There was a difference of opinion as to whether the county society had anything to say about this plan. They attempted to make this group report to the county society and as a result received a letter saying that the county medical society had rejected the Federal plan and they (HMSA) didn't have to report on it.

He commented on the Foundation, which the HMSA seemed to think was in opposition to them, this is not so. When Dr. Harrington, one of the founders of the original Stockton plan, was in Honolulu he met with the HMSA executive committee and told them that they were missing the boat. They should have every doctor in the state 100% behind them and should offer everything that the Stockton plan includes. Dr. Hartwell said he set up a meeting with the Board of Directors and the Honolulu County Board of Governors. He had been told it wouldn't accomplish anything and it didn't. Nevertheless it took place and the two groups had an opportunity to meet one another. Next the officers decided that they would meet with the executive committee of the HMSA. If they hadn't done that and had turned it over to the Medical Care Plans Committee, they might have been better off. They met for a couple of hours and pointed out that the Society would like to have a common form of contract whether it was for the Federal employees or not and that we would like better policing of HMSA. They went further than the Board of Governors had directed and said they would be perfectly willing to have the doctors sign individual contracts under a master contract and if for any reason the HMSA wanted to drop a participating physician, they could do so with 30 days' notice, and so could the society.

The answer to this was the letter dated May 26 canceling the contract. After that there was a pause as three of the HCMS officers took their vacations at the same time and did not appoint anyone else to carry on these negotiations.

On June 9 Dr. Burden wrote a letter to Mr. Oliphant.

Dr. Hartwell felt that Dr. Burden had acted as a state association president should.

The House granted Mr. Kennedy the privilege of the floor. Mr. Kennedy said that when Dr. Hartwell got back from his vacation he asked to meet with Mr. Veltmann for lunch. Mr. Veltmann suggested that the HMSA and HCMS might better meet together at the staff level and then bring information back to their policy making levels. In all the negotiations which were entered into, policies were set forth only for Honolulu County and at no time did they speak for the other islands. There are now ten points in the proposed contract which were more or less approved by the membership. These are:

1. There shall be only one form of participating physicians' agreement, that is to say, there will not be one for the Federal plan, one for the basic plan, etc.
2. Participating physicians' agreements shall be for a term of one year and shall have a 30-day cancellation clause in them, which can be used either by the HMSA or the participating physician.
3. There will be no changes made in the HMSA constitution and bylaws, fee schedules, or administrative operating procedures, without approval of the Society.
4. The Medical Director of HMSA and any of his assistants (meaning doctors) shall not be appointed except after consultation with the Society and then only if the Society does not disapprove of such appointees.
5. It is agreed that the Society shall annually nominate 9 of its members who are HMA participating physicians for consideration by the nominating committee of HMSA as nominees for election to the HMSA Board and that from such nominees of the Society, three shall be nominated for election by the directors. (Three are elected each year for a two-year term. Total number for Honolulu is 6.)
6. HMSA will not exercise its right to cancel any participating physician's contract after 30 days' notice, unless such cancelation has been recommended by the appropriate medical committee of HMSA and finally approved by the executive committee of the HMSA. (Only physicians may initiate a recommendation for cancelation of the individual contract.)
7. All physician committees of HMSA, other than the Medical Committee, shall be appointed by the President of the HMSA and shall be in direct proportion to the number of participating physician in each of the counties of the State. The Society shall provide the president of HMSA with a list of not less than three times the minimum number of appointees required to be appointed. (The number to be submitted shall never be less than five and all must be participating physicians.)
8. No changes to existing plans or new plans will be offered or introduced which affect the total charges participating physicians may make for any service or procedure, except with the prior approval of the Medical Care Plans Committee of the Society.
9. HMSA agrees that not less often than annually it shall review and confer with the appropriate committees of the Society with regard to fee schedules.
10. This contract shall be on an annual basis with no 30-day cancelation clause.

The current status of negotiations is that Mr. Veltmann has given a copy of the proposed contract to the HMSA attorney who will go over it for legality, not policy. Mr. Kennedy thought that negotiations would probably be concluded within a week.

Mr. Kennedy spoke on the individual contracts and their unsatisfactory terms. Lifetime contracts were distributed. HCMS is proposing annual contracts. Under lifetime contracts, the Society cannot suggest to its members that they be canceled. Annual contracts can lapse.

Mr. Kennedy advised that the HMSA Board of Directors voted to eliminate alternate directors. There was a move by the lay directors to have alternate directors for every member on the Board. In the Bylaws, the Board can appoint an alternate for any director. He said he thought that if this contract is negotiated here in Honolulu, the identical contract will be made with the other counties in the state.

Dr. Sloan asked Mr. Kennedy if he felt that Mr. Veltmann would go along with the proposed contract and try to influence his directors to approve it. Mr. Kennedy said he couldn't see how he could help but make the recommendation to his executive committee. It would seem that he would make such a recommendation. However, when Mr. Veltmann was advised that the proposed contract would come back to the Medical Care Plans Committee, he said he was going to hand it to his executive committee and let them decide.

Mr. Kennedy said that in the beginning, he thought that HMSA might desire to contract on a state level but at the previous day's meeting, Mr. Veltmann made it

(Continued on page 88)

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(Continued from page 86)

clear that this point is the doctors' decision and he would not enter into it in any way.

Dr. Burden thanked Mr. Kennedy and complimented him on the manner in which he had been conducting the negotiations. Perhaps if this approach had been used at the start of the trouble, there would have been less trouble all around. He thought that there was no doubt that the way medical things are going, there is need for unity and that is one possible argument to have the contract on a state level—to act as a unified group rather than as splinter organizations. That the smaller societies, Maui at least, have always gone along with Honolulu but they can't help but feel like step children in many ways.

Dr. West said that he thought that everything had been thoroughly discussed and moved that the meeting be adjourned.

Dr. Sloan asked if anything came out of the Council meeting. Dr. Burden advised that other actions were taken but a special meeting is limited to the subject for which it is called.

Dr. Hartwell said he realized that it is expensive and time consuming to come here but thought that perhaps we ought to have two or three meetings of the House of Delegates every year and maybe something could be done to promote more frequent meetings.

The meeting adjourned at 8:57 P.M.

Respectfully submitted,
RODNEY T. WEST, M.D.
Secretary

BOOK REVIEWS

(Continued from page 59)

as they exist today. In addition, it provides a background for understanding oncoming problems.

After an introduction to terms and types of radiation, Dr. Shilling puts in perspective the sources of radiation to the human body (cosmic rays, fallout, medical uses); their effect on the individual and on the race; and the fundamentals of radiation safety. Despite the misleading subtitle, much of the content applies directly to the doctor. The usefulness of radioactive isotopes in clinical diagnosis and treatment, as well as details of the effect of excessive radiation on the human body from accidents or bomb explosions, are outlined.

This booklet can be recommended heartily as a lucid introduction to the problems of radiation for those involved in the daily care of patients. Even those working directly in radiology or nuclear medicine will find it a balanced review and handy reference.

ROBERT A. NORDYKE, M.D.

The Principles and Practice of Medicine, 5th Ed.

By Sir Stanley Davidson, B. A., Cantab, M.D., F. R. C. P. Edin, F. R. C. P. Long., M.D., Oslo, R. F. S. Edin, 1112 pp., $8.00, The Williams and Wilkins Co., 1960.

This textbook is excellent for brief, rapid review of internal medicine. It would be ideal for someone who is not in the field of internal medicine. It may not be completely adequate for an internist but may help him in refreshing his memory. All the articles are short, concise, clear, and quite complete. The normal and abnormal physiological processes are current and discussed as often as necessary to classify the subject. The interpretation of signs and symptoms is especially good and much superior to the manner in which it is handled in Cecil and Loeb's *Textbook of Medicine*. Most of the current medications are adequately discussed.

U. GOTO, M.D.

Haemopoiesis—Cell Production and Its Regulation.

By E. W. Wolstenholme, OBE, MA, MB, MRCP, and Maeve O'Connor, Eds., 490 pp., $11.00, Little, Brown and Company, 1960.

This symposium on the kinetics of blood cell production will be of interest only to investigators concerned with the mechanism of hematopoiesis.

THOMAS FUJIWARA, M.D.

Clinical Cardiopulmonary Physiology

Edited by Burgess L. Gordon, 2nd Ed., 1001 pp., $28.50, Grune & Stratton, 1960.

This is an entirely new edition with significant improvement over the first. An almost overwhelming undertaking because of multi-authorship, it nevertheless will serve its function admirably. Deficiencies stem from multi-authorship and in many areas too narrow a field is covered, limited to a single investigator's interest. The third edition should aim to correct this deficiency.

BERNARD J. B. YIM, M.D.

(Continued on page 90)



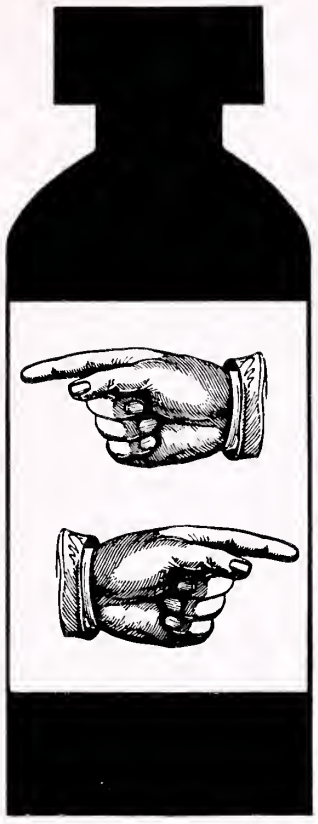
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BOOK REVIEWS

(Continued from page 88)

★Clinical Management of Behavior Disorders in Children

By Harry Bakwin, M.D., 597 pp., $11.00, W. B. Saunders Co., 1960.

This second edition follows the outline of the first edition. The contents of each chapter have been generally preserved. Principal changes are noted in minor revisions of paragraphs here and there. These are limited largely by the fact that the first edition had been so well written. The addition of sections on Duodenal Ulcer, Early Infantile Autism, Manic-Depressive Disease and Hysteria increase the effectiveness of this excellent text. Written in a sensitive, clear and effective style, this book maintains its position as an essential text book for all who deal with the emotional problems of children.

DUKE CHO CHOY, M.D.

★Surgical Treatment of Trauma

By Preston A. Wade, M.D., Ed., 779 pp., $26.50, Grune & Stratton, 1960.

This text of 750 pages covers practically every phase of trauma, although, as might be expected, it is largely devoted to the management of injuries of the bony skeleton.

It is thorough and comprehensive, and for the general practitioner, or the general surgeon, I think it would serve as an excellent reference in that it has chapters devoted to the management of multiple injury cases as well as chapters outlining pertinent data concerned in trauma of such anatomical systems as head and neck injuries to the nervous system, and the urinary tract.

It is well organized and contains numerous excellen illustrations. The style of writing makes for easy in gestion and assimilation of the information containe therein.

JAMES W. CHERRY, M.D.

★Diagnosis and Treatment of Menstrual Disorders and Sterility, 4th Ed.

By S. Leon Israel, M.D., 666 pp., $15.00, Paul B. Hoeber Inc., 1959.

This is an excellent book; its chapters are well outlined, and the material reflects the author's clear and logical method of presentation which is well known by those who know him. The approach to endocrine and infertility problems is clear and practical.

An excellent book for general practitioner or specialist, it will be particularly helpful for those who meet endocrine problems infrequently. The book is well printed and bound. It is highly recommended.

C. C. MCCORRISTON, M.D.

★Occupational Therapy in Rehabilitation

By E. M. Macdonald, B.Litt., TMAOT, Ed., 348 pp., $8.50, Bailliere, Tindall and Cox, 1960.

This book should be included on the required list for undergraduate students in occupational therapy and recommended reading for those considering careers in occupational therapy.

The book would be especially important for occupational therapy students who do not have regular exposure to discussion and lectures on the diseases found



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the patients that the occupational therapist will be ked to serve.

The occupational therapist working in rehabilitation nters or hospitals with regular discussions on the med- al aspects of their patients would not necessarily need add this book to their libraries.

R. Frederick Shepard, M.D.

Neurochemistry of Epilepsy

By Donald B. Tower, M.D., Ph.D., 335 pp., $9.00, Charles C. Thomas, 1960.

One of the foremost neurochemists of today, Dr. Donald B. Tower from the National Institute of Health, has done an excellent job of presenting current concepts regarding the neurochemical mechanisms responsible for seizures. Briefly but concisely he discusses the important aspects of cerebral oxidative metabolism, amino acid metabolism and electrolytes and transmitters involved in neural function with special emphasis on those particulars which are felt to be important in seizures. In addition, factors affecting anticonvulsant action and the possible modes of action of anticonvulsants are presented.

The book is quite devoid of complex chemical formulae and technical details and the material is presented in very readable and relatively simple language. Although written primarily for the clinician and students in neurology and allied fields who are usually without much of a chemical background, each chapter is well supplemented by a bibliography for the neurochemist and other investigators.

Michael M. Okihiro, M.D.

★Complications in Surgery and Their Management

Edited by Curtis P. Artz, M.D., F.A.C.S., and James D. Hardy, M.D., F.A.C.S., 1075 pp., $23.00, W. B. Saunders Company, 1960.

This is a monumental compilation of almost any complication possible in general surgery or its related specialties. It is thorough, well written, and documented with a more than adequate bibliography. The illustrations are few, but are presented where necessary, and are informative. The authors have devoted particular attention to the newer developments in surgery—for example, vascular surgery—but have wisely excluded such developing fields as extra-corporeal oxygenators. This volume will be particularly valuable to the occasional operator, but helpful also to the surgical specialist.

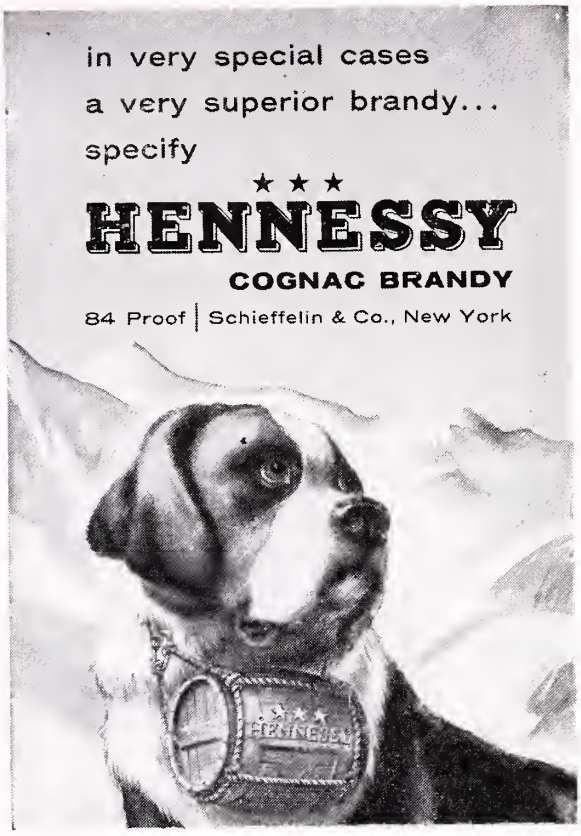
R. G. Johnston, M.D.

Diagnostic Roentgenology of the Digestive Tract Without Contrast Media

By Bernard S. Wolf, M.D., Mansho T. Khilnani, M.B., and Arthur Lautkin, M.D., 180 pp., $8.75, Grune & Stratton, Inc., 1960.

The authors emphasize the amount of important diagnostic information which can be gleaned from plain films of the abdomen without employing the usual opaque media. While x-rays faithfully record disease lesions, many valuable leads may be lost by hurried or casual scanning of films. Most of the examples shown (such as air outlining a gastric ulcer crater or in colon diverticula) require confirmation by opaque substances and I suspect were often seen in retrospect. The authors should be complimented on their careful study and follow-up of cases.

(Continued on page 92)



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BOOK REVIEWS

(Continued from page 91)

The value of the book is in the numerous illustrations which are superb reproductions of fascinating roentgenograms with well-phrased captions. By comparison, the text is rather dull and unnecessary.

Radiologists' diagnostic acumen and awareness would be sharpened by recalling the examples presented.

ROBERT G. RIGLER, M.D.

A Synopsis of Contemporary Psychiatry

By George A. Ulett, and D. Wells Goodrich, 309 pp., $6.50, The C. V. Mosby Co., 1960.

This rather comprehensive manual covers the field of psychiatry in outline fashion very well. The material is reliable, convincing, and clearly presented. This volume serves very well for a student or for a general practitioner, and as a refresher outline for the specialist.

The field of tranquilizers is very reasonably and comprehensively covered. It is a rather good synopsis of psychiatry brought up to date.

J. ROBERT JACOBSON, M.D.

★An Atlas of Bronchoscopy

By A. Huzly, M.D., 94 pp., $12.50, Grune & Stratton, 1960.

This atlas should be in possession of everyone doing bronchoscopies. It contains 180 photographs obtained with an ingenious German-manufactured optical camera system. Most of the photographs are in color, and while for teaching purposes they are not as valuable as the monumental drawings of Chevalier Jackson, for practical purposes they are perhaps superior. Almost all types of pathologic changes in the tracheobronchial tree are illustrated. Of particular value are repeated photographs showing changes in severity of disease and in healing processes. A photographic apparatus of this nature would be of inestimable value to record surgical results in anastomoses and grafts of the tracheobronchial tree. The first part of the book deals with indications, technique, and anatomy, and would be of value to anyone learning to perform bronchoscopies.

PAUL W. GEBAUER, M.D.

★Management of Hypertensive Disease

By Joseph C. Edwards, 439 pp., $15,00, The C. V. Mosby Co., 1960.

This monograph is filled with practical gems. The author emphasizes the false high readings obtained in obese persons. He goes on to outline how taking the blood pressure in the forearm gets around this very effectively.

Another not well known point is emphasized—the prognostic value of basal blood pressure readings and the technique of getting them in an office practice. The casual blood pressure is denounced as being unreliable and should give way to the basal reading in evaluation of any therapeutic regimen.

All therapeutic regimens are given in fine detail, including what the patient should be given in writing.

For those wishing to be brought up on the theory and fine details of all aspects of the problem of hypertension, the author has a concluding chapter summarizing important physiology and experimental work plus a bibliography of 1,622 references.

(Continued on page 94)



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BOOK REVIEWS

(Continued from page 92)

This is a very readable and serviceable book, meetir the needs of both the busy practitioner who wants thin at his fingertips and also the man who wants to pursu the minutiae of the subject—a very rare achievement.

RAYMOND M. DEHAY, M.D.

★Diagnosis and Treatment of Tumors of the Chest

Edited by David M. Spain, M.D., 371 pp., $14.75, Grur & Stratton, 1960.

This significant contribution to our knowledge c tumors of the chest is sponsored by the American Co lege of Chest Physicians on the occasion of their 25t anniversary. It sums up clearly and concisely our know edge regarding these lesions.

Dr. Spain and 25 other distinguished contributo comprising the fields of chest medicine, radiolog pathology, and surgery have done an excellent job i condensing the vast amount of material that has com to light in this field in recent years. This is a volum of particular importance to those dealing in che diseases. However, it is an excellent reference book fc all clinicians. As might be expected, most of the boo is taken up with carcinoma of the lung. Approximatel 100 pages deal with the etiology, pathogenesis, patho ogy, diagnosis, and treatment of bronchogenic carcinom Neoplasms of the mediastinum, pleura, chest wall, d aphragm, esophagus, and heart are also dealt with i some detail. Particular emphasis is placed on the prove methods of treatment at the present time.

(Continued on page 96)

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BOOK REVIEWS

(Continued from page 94)

The writing of this volume is clear and concise; the x-ray reproductions are particularly excellent, as are the histologic sections.

NIALL M. SCULLY, M.D.

★Occupational Diseases and Industrial Medicine

By Rutherford T. Johnstone, M.D., and Seward E. Miller, M.D., 482 pp., $12.00, W. B. Saunders Co., 1960.

This book, written by two experts on the problems of industrial medicine, is in an easy-to-read style which quite painlessly conveys an astonishing amount of information. The case histories and illustrations of the text are excellent, although the reproduction of lung films lacks contrast.

An unusually interesting chapter entitled "Occupational Cancer" begins with the history of the first recognized cancer probably resulting from occupation, a scrotal lesion encountered in chimney sweeps by Percival Pott in 1775.

The chapters on synthetic resins, pesticides, and rocket fuels are surprisingly up to date, offering specific advice on handling materials as well as patients in contact with these substances.

Although it is not a classic, this is an excellent book.

F. L. TABRAH, M.D.

Also Received

★Medical Almanac, 1961-62

Compiled by Peter S. Nagan, 528 pp., $5.00, W. B. Saunders Company, 1961.

Organizations and Officials; Publications and Meetings; Education and Research; Vital Statistics; Medical Manpower; Costs of Illness; these are a few of the chapter headings. A diamond mine of information for those who need it—or who merely enjoy it!

Adrenergic Mechanisms

G. E. W. Wolstenholme, Maeve O'Connor, and J. R. Vane, Eds., 632 pp., $12.50, Little, Brown & Company, 1960.

An important reference work, though not one for your desk-top library.

The Chemical Basis of Clinical Psychiatry

By A. Hoffer, M.D., and Humphry Osmond, M.R.C.S D.P.M., 277 pp., $8.50, Charles C. Thomas, 1960.

Here is the evidence that anxiety results from a rise i the ratio of adrenaline to leuko-adrenochrome.

The Surgical Clinics of North America, Vol. 41, No. 2

Frank Glenn, M.D., Guest Editor, pp., 265-544, W. E Saunders Company, April, 1961.

This volume from the New York Hospital Corne Medical Center deals with the surgery of the heart an large vessels. Twenty-one contributors.

★Atlas of Tumor Pathology—Section IX, Fascicle 33, Tumors of the Female Sex Organs, Part 3, Tumors of the Ovary and Fallopian Tubes

By Arthur Hertig, M.D., and Hazel Gore, M.B., 177 pp $1.40, Armed Forces Institute of Pathology, 1961.

Every pathologist will want to own this beautifull produced and authoritative pamphlet. The illustration (157 of them, 8 in color) are excellent. Two pages o color.

★Metabolic Effects of Adrenal Hormones

G. E. W. Wolstenholme, and Maeve O'Connor, Eds 109 pp., $2.50, Little, Brown and Company, 1960.

The internist with special interest in endocrinolog and metabolism can hardly afford to miss this littl volume.

Essential Hypertension— An International Symposium

K. D. Bock and P. T. Cottier, Eds., 392 pp., $8.12 ap proximate, Springer-Verlag, 1960.

Another CIBA symposium, with 38 participants tron many countries. The interchange of ideas makes fasci nating reading.

Cerebro-Spinal Fluid Dynamics in Health and Disease

By David Bowsher, M.D., 80 pp., $4.75, Charles C Thomas, 1960.

For neurosurgeons especially. Pediatricians managin hydrocephalus would find it valuable too.

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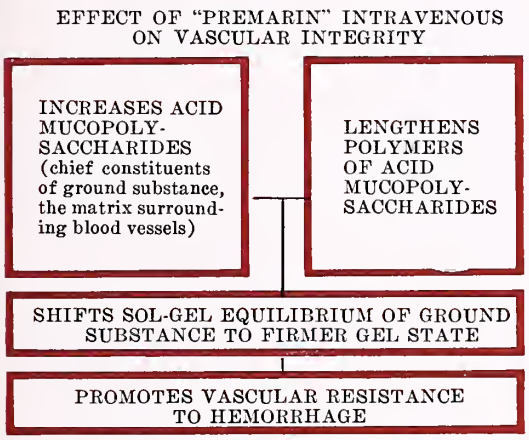
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*Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. **73**:43 (Jan.) 1961.

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	Page
American Cancer Society	28
American Factors, Ltd.	94
American Tobacco Co.	15
Ames Company	14, 99
Ayerst Laboratories	97
Baxter, Don, Inc.	16
Burroughs Wellcome	18, 81
Carnation Company	19
Coca-Cola Bottling Co.	92
Eaton Laboratories	7, 93
Endo Laboratories	5
Farrar, R. J.	91
General Electric Co.	10
Hawaii Medical Service Association	56
International Travel	88
Lederle Laboratories	82, 83
Lilly, Eli & Co.	1, 32
Lorillard, P.	25
McKesson & Robbins, Inc.	90
Mead Johnson International	100
Medical Industries	74
Merck, Sharp & Dohme	17
O'Leary, Lydia, of Hawaii	24
Optical Dispensers	92
Pacific West Distributors, Ltd.	24
Pali Medical Bldg.	22
Parke, Davis Company	2, 3
Pfizer Laboratories..Insert (between pages 20 and 21),	21
Pharmaceutical Manufacturers Assn.	89
Professional Machine Accounting, Hawaii	87
Professional Services, Inc.	30
Robins, A. H. Co., Inc. Insert (between pages 10 and 11),	11, 27, 85
Ross Laboratories	12
Saunders, W. B. Co.	29
Schering Corporation	31
Schieffelin & Co.	91
Searle, G. D. & Co.	63
Security Diamond Company	79
Smith, Kline & French	26
Squibb, E. R. & Sons	8, 9, 77
Star-Bulletin Printing Co., Inc.	71
Summers, Clinton D.	94
Tailby-Nason Co.	23
Today's Health	73
Universal Motors	20
Upjohn Company	95
Von Hamm-Young Co., Ltd.	24, 98
Warren-Teed Products Co.	75
Wesson Oil & Snowdrift Co.	64, 65
Williams Mortuary	96
Winthrop Laboratories	13

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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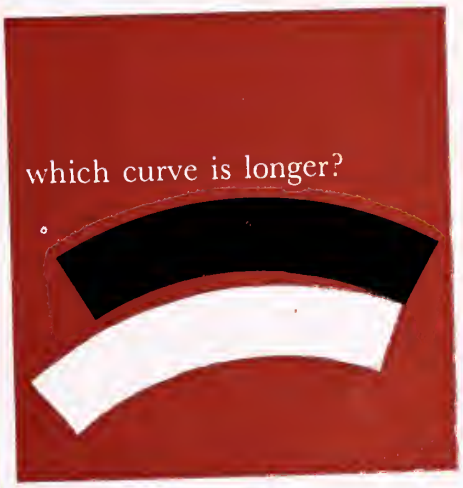
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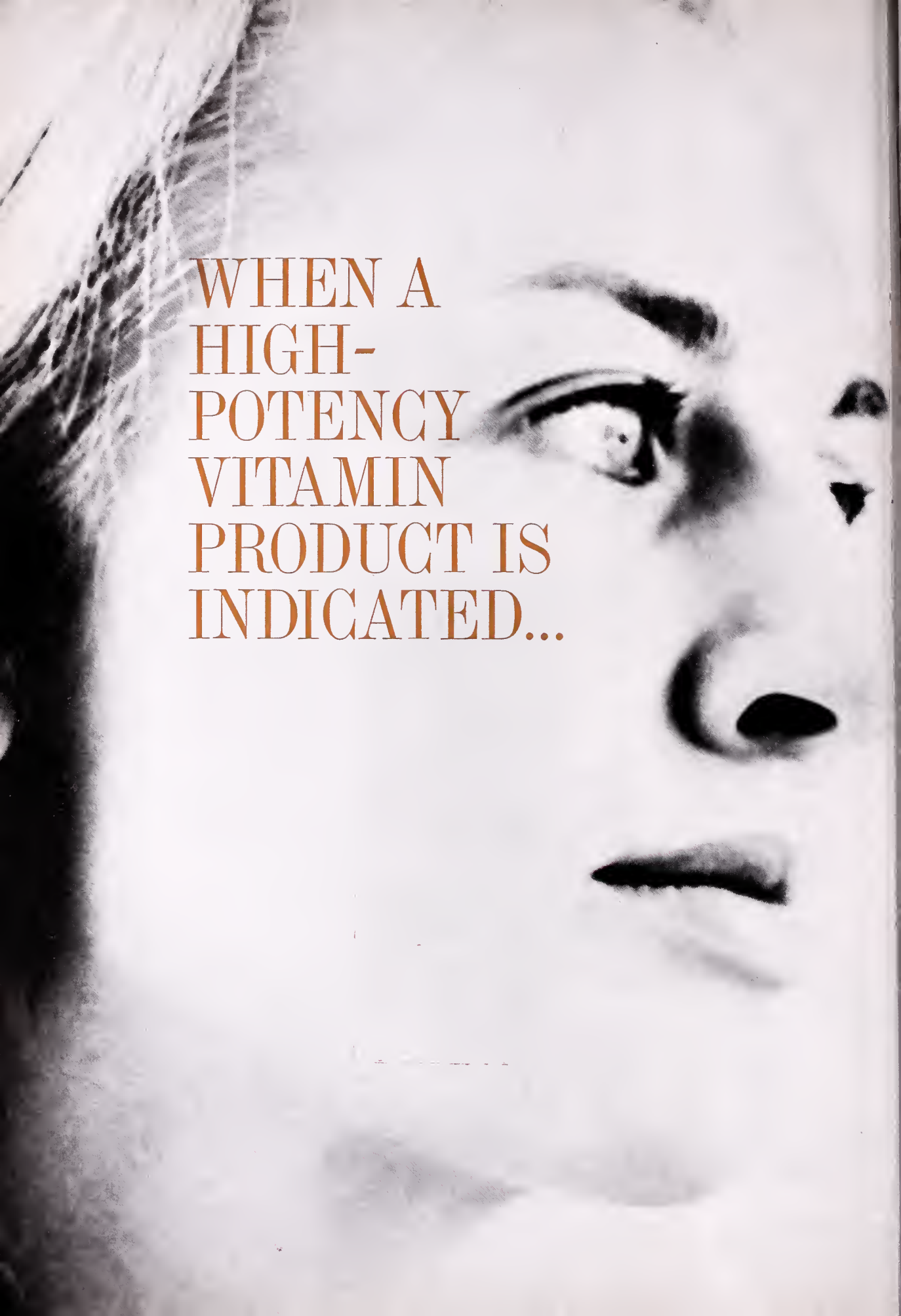
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Contents

Scientific Articles

Artificial Kidney—"Nephromime" ..... Paul Y. Tamura, M.D., and W. Harold Civin, M.D. 125

Experiences with the Artificial Kidney at The Queen's Hospital ..... Shigeru Richard Horio, M.D. 131

Parasitic Meningo-Encephalitis in Hawaii ..... Shigeru Richard Horio, M.D., and Joseph Alicata, Ph.D. 139

Duodenal Ulcer in a Premature Infant ..... Walter Y. M. Chang, M.D., and Horace Warden, Capt. (MC) USN 144

Liver and Biliary Tract Function Testing With Radioiodinated Rose Bengal ..... Robert A. Nordyke, M.D. 144

Editorials

No Hurry About Oral Polio Vaccine 147

Medication by Government Fiat 148

No More Scruples 148

Features

Book Reviews 153

County Society Reports 152

In Memoriam—Doctors of Hawaii—XXXV 151

Notes and News 154

President's Page 146

This is What's New! 149

Inter-Island Nurses' Bulletin

General Interest 158

Book Reviews 162

Hawaii Technologists' Bulletin

..... 164



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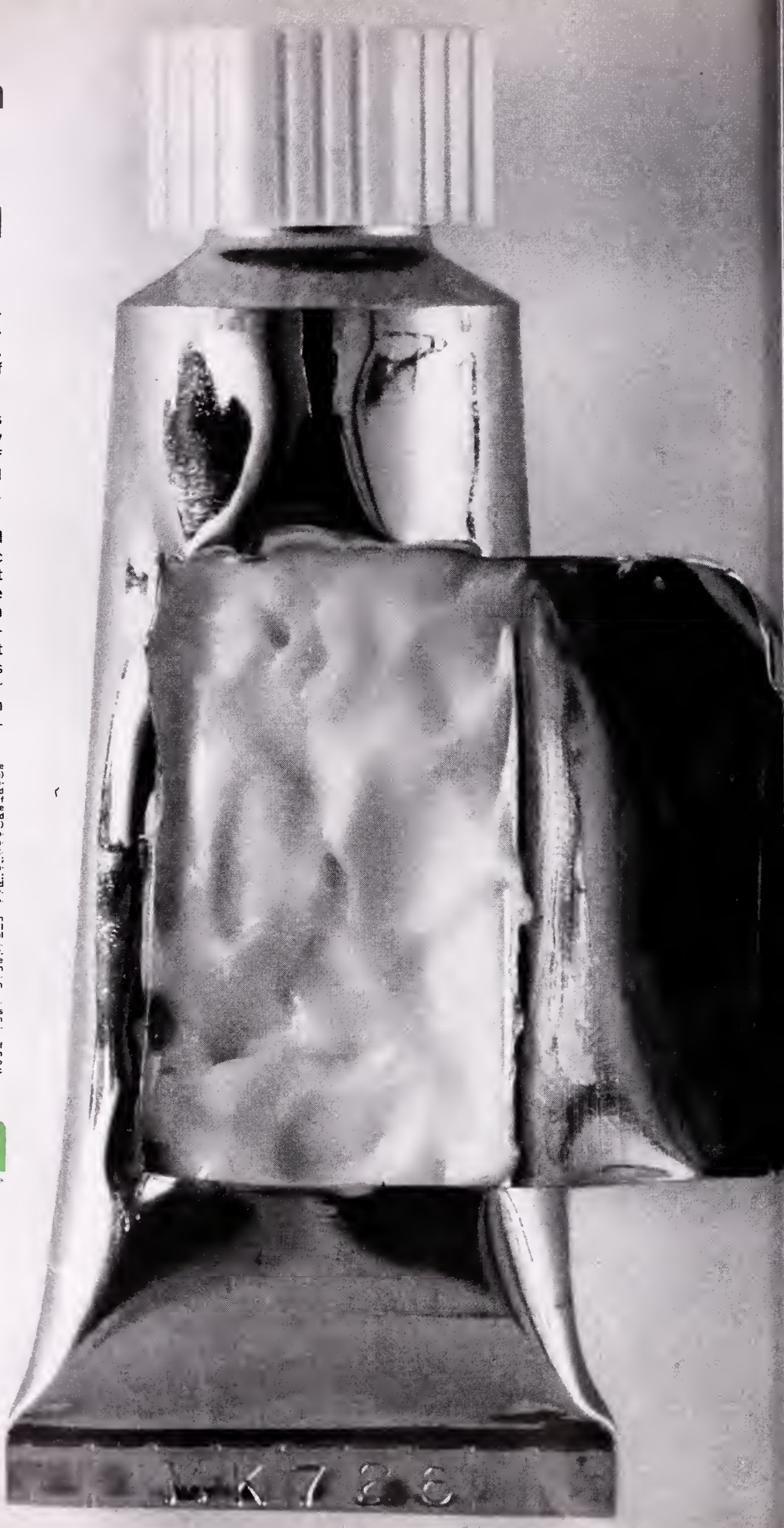
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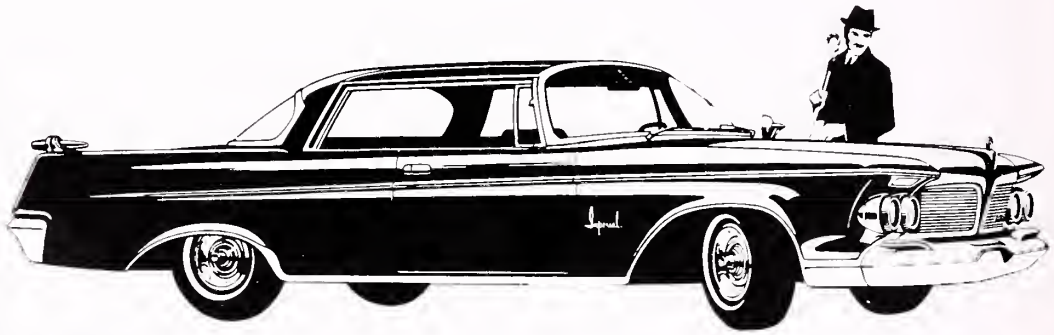
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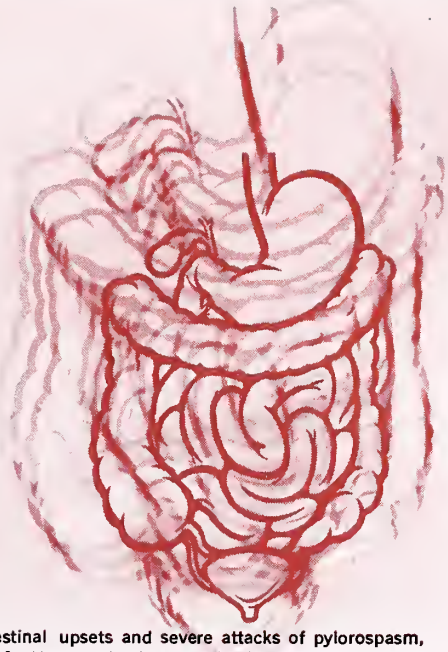
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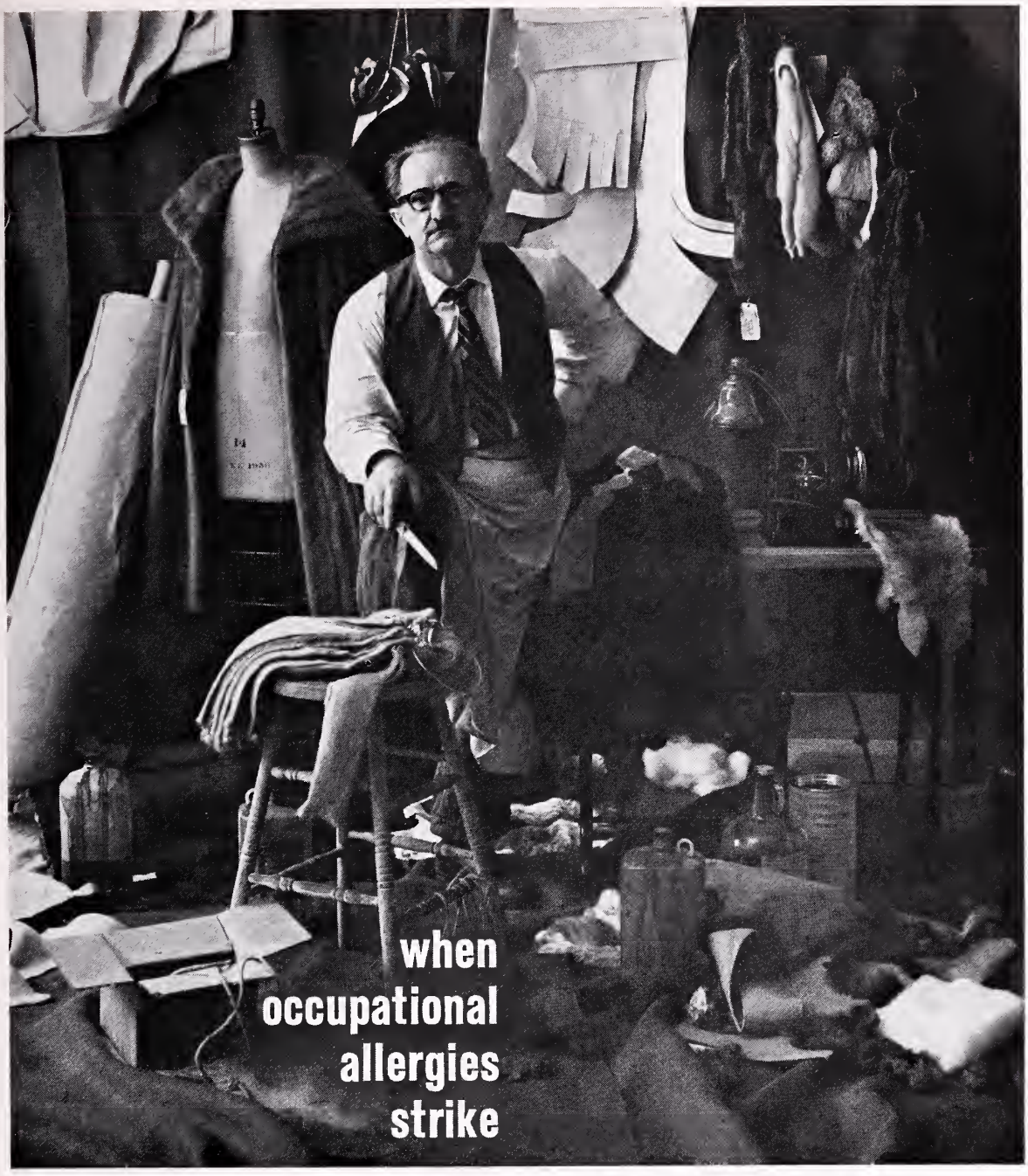
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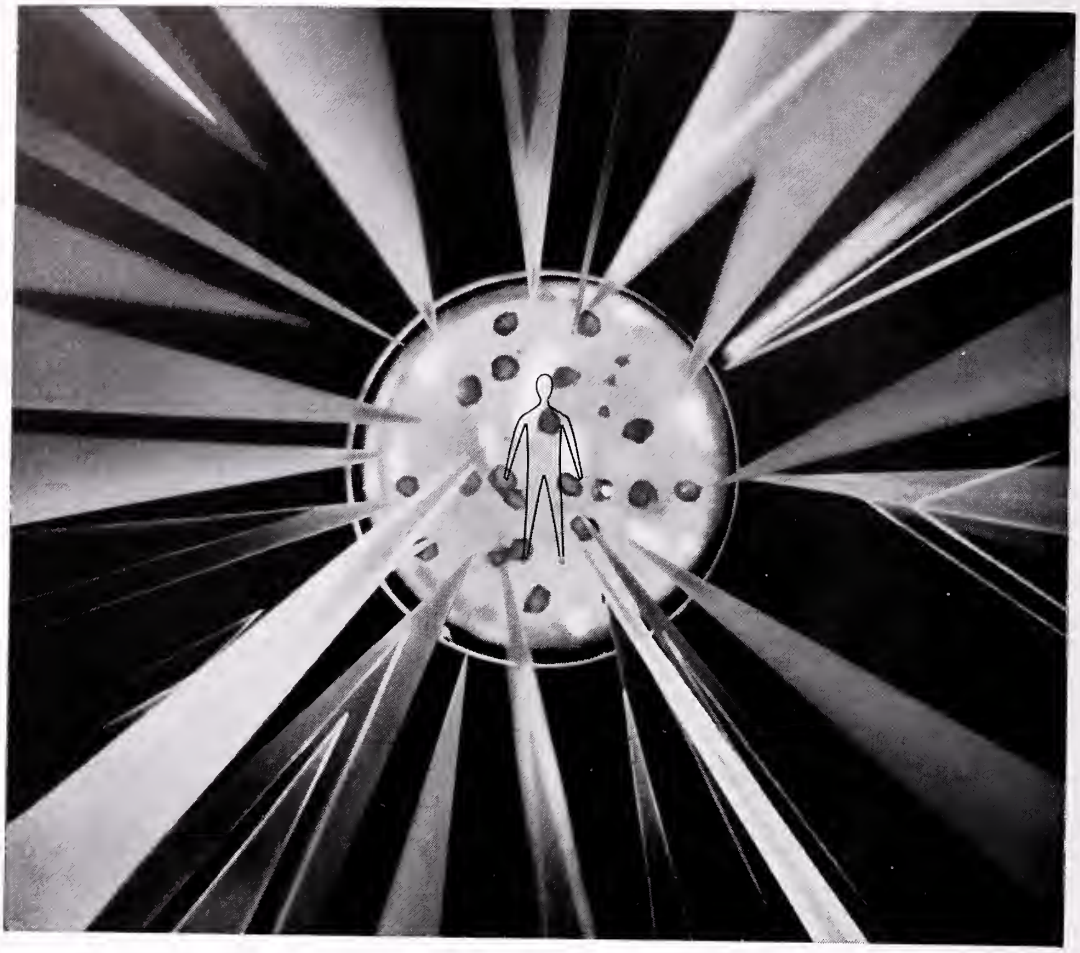
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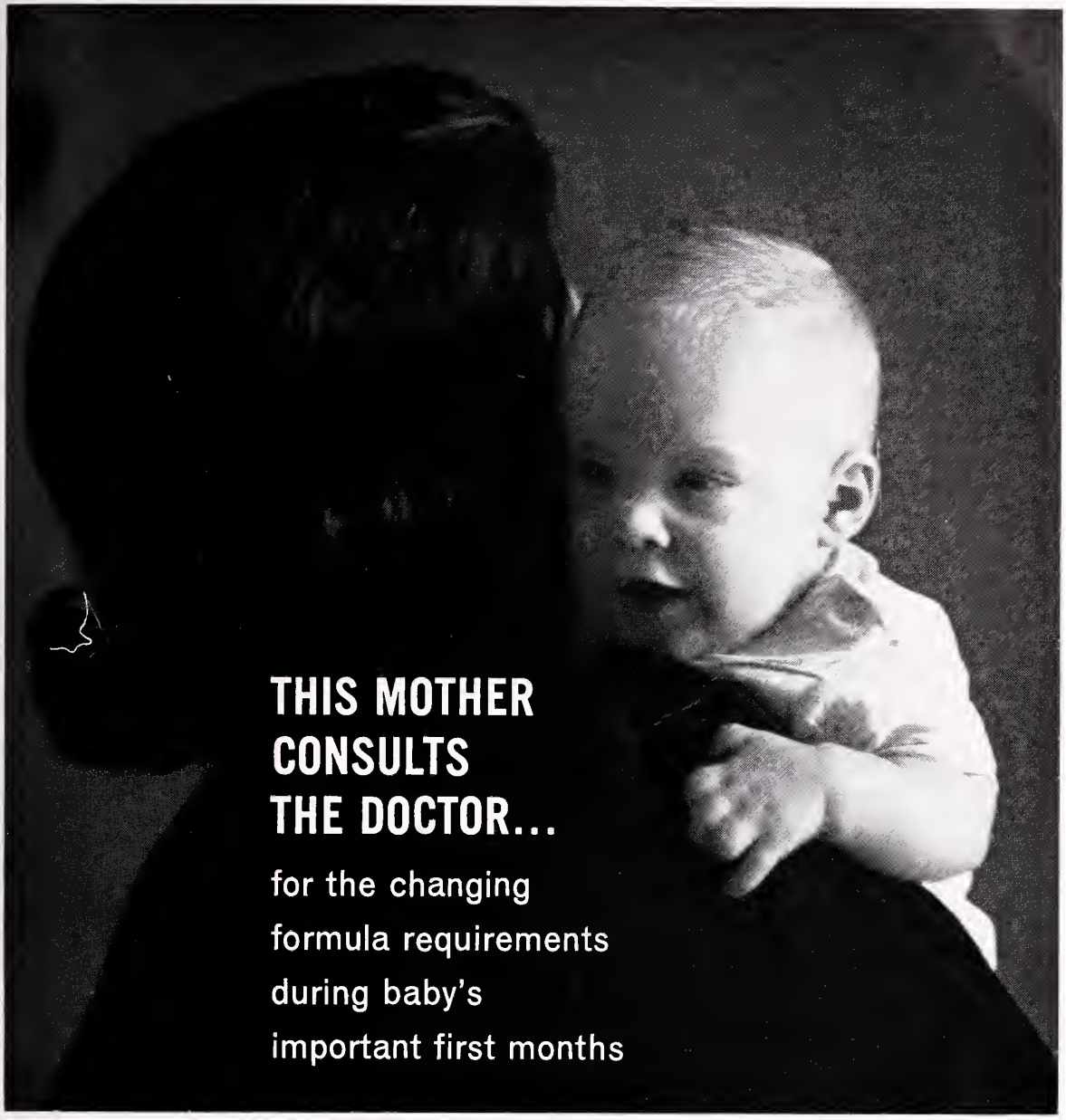
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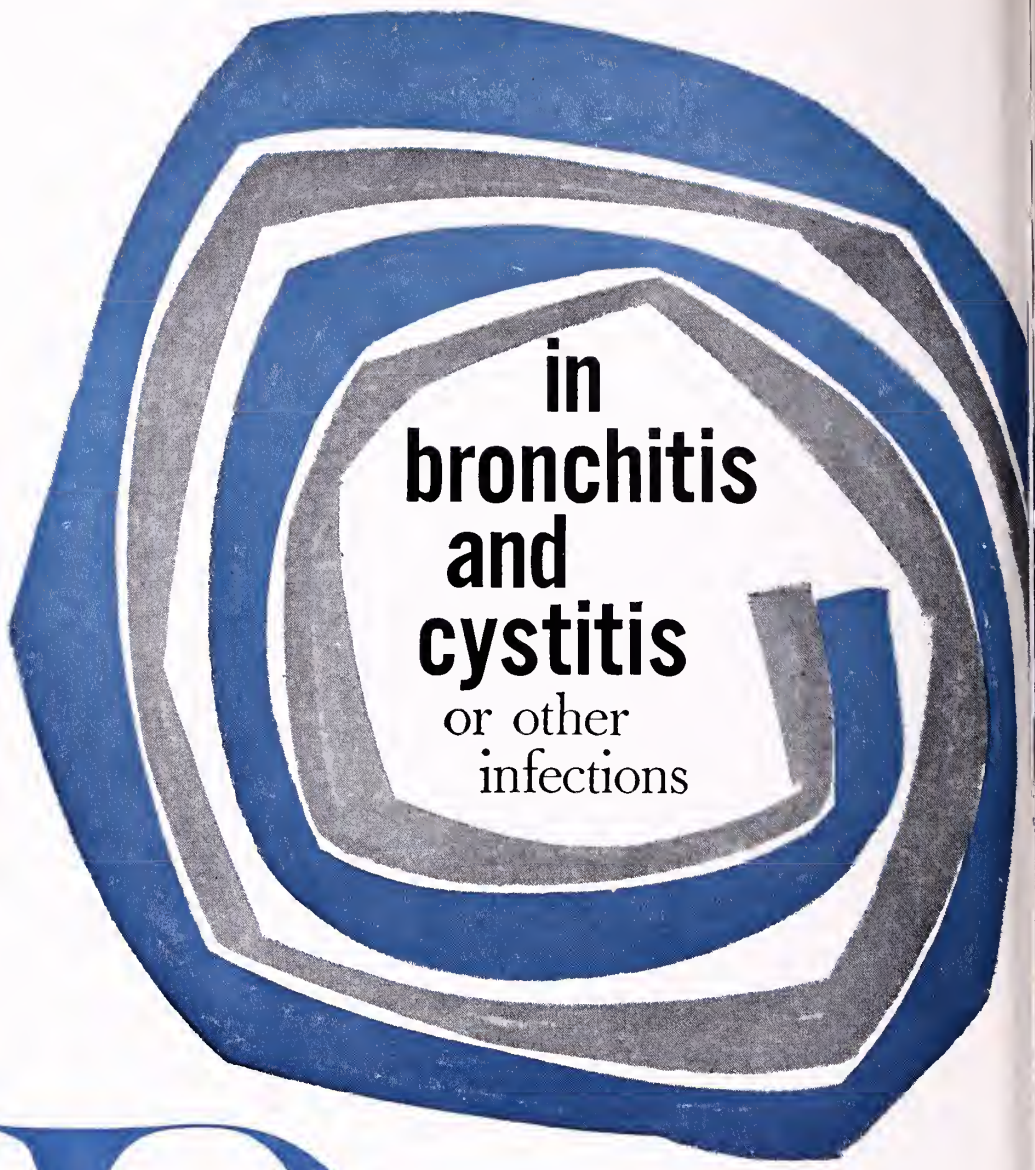
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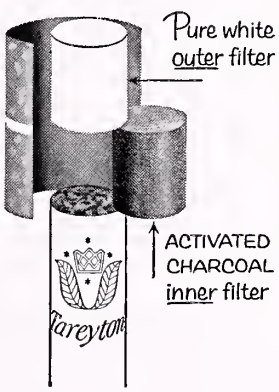
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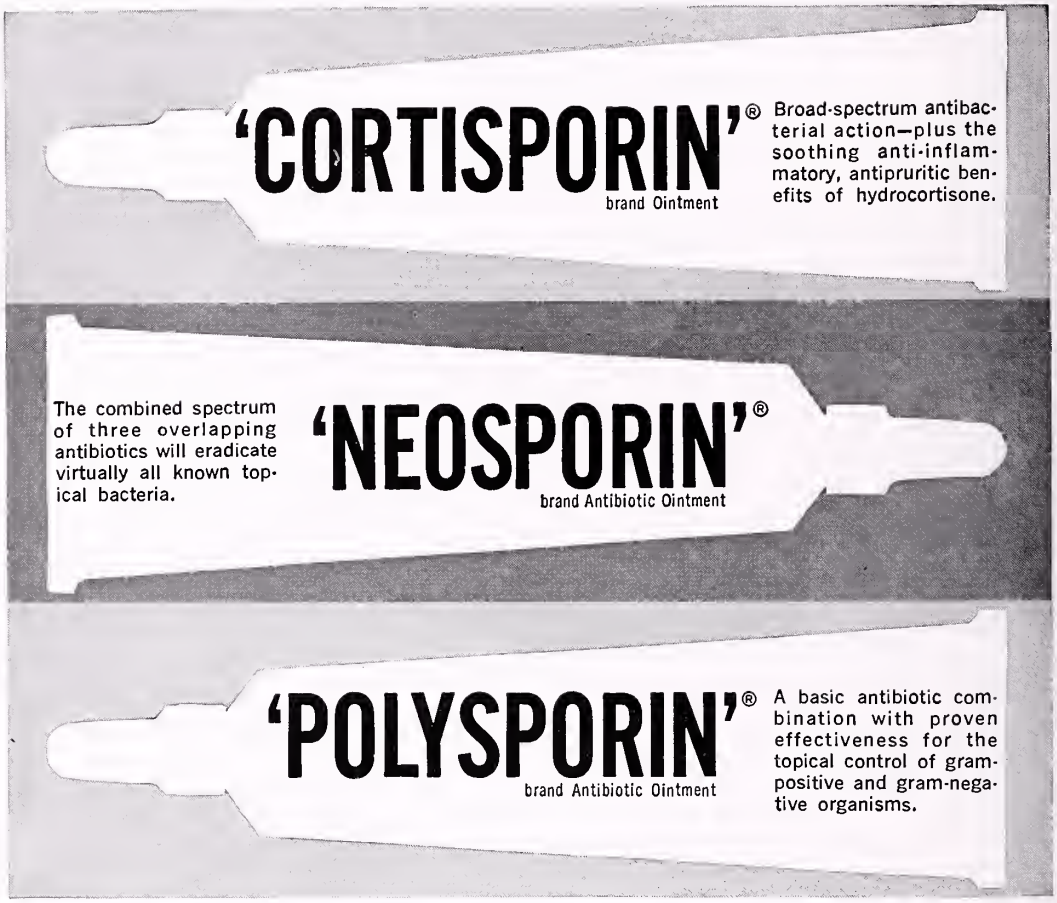
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Artificial Kidney–"Nephromime"*

Indications

PAUL Y. TAMURA, M.D.,† and
W. HAROLD CIVIN, M.D.,‡ Honolulu

IN MARCH OF 1958, The Queen's Hospital acquired the Kolff Twin-coil Artificial Kidney (Travenol), and a few months later (June) a patient in advanced renal failure was dialyzed. The result was dramatic. The dulled sensorium cleared and the blurred vision disappeared, as did the twitching, nausea, and vomiting. However, it wasn't long before this patient deteriorated, first chemically, then clinically, and died in a matter of several weeks. This case illustrated the potentiality of the machine and, at the same time, its limitations.



Bauer

DR. TAMURA

The artificial kidney (nephromime) is a machine designed to correct the chemical abnormalities in the blood by dialysis through a semipermeable membrane. The nephromime we acquired is but one of several types of machines available. Details regarding this and other nephromimes, including technical aspects, are discussed elsewhere.[2] To date, 40 dialyses have been performed on 25 patients at this hospital. Only rare and minor technical problems were encountered.

It is our impression that many physicians are confused about indications for the use of this therapeutic tool. The voluminous literature from various centers gives the impression that there are major differences of opinion among the authorities in the field.[3] For this reason, we are presenting this problem in the light of our own experience with the hope that we may help clarify the situation rather than add to the confusion.

* It has been suggested by van Bergeijk that the suffix—*mime* (from Greek stem μιμη = imitate, as in pantomime) be used for man-made devices which simulate biologic function. The suffix is attached to the stem of the word that designates the organ being simulated. Thus, *nephromime* for artificial kidney, *cardiomime* for cardiotron, *neuromime* for transistorized artificial neurons, etc.[1]

† Associate Director of Laboratories.
‡ Director of Laboratories, The Queen's Hospital.

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[1] van Bergeijk, W. A.: Nomenclature of devices which simulate biologic functions, Science 132:1248 (Oct. 28) 1960.

[2] (a) Kolff, W. J.: The artificial kidney; past, present, and future, Circul. 15:285 (Feb.) 1957. (b) Merrill, J. P.: Medical progress: The artificial kidney, New Engl. J. Med. 246:17 (Jan. 3) 1952. (c) MacNeill, A. E., Witebsky, E., and Swanson, P. R.: Unusual hemolytic transfusion reaction with renal failure treated by hemodialysis, J.A.M.A. 161:1630 (Aug. 25) 1956. (d) Skeggs, L. T., Jr., Leonards, J. R., and Heisler, C. R.: Artificial kidney. II. Construction and operation of an improved continuous dialyzer, Proc. Soc. Exper. Biol. & Med. 72:539 (Dec.) 1949. (e) Maher, F. T., and Broadbent, J. C.: Extracorporeal hemodialysis in the management of acute renal failure, J.A.M.A. 166:608 (Feb. 8) 1955. (f) Kupfer, S., and Rosenak, S. S.: A new parallel tube continuous hemodialyzer, J. Lab. & Clin. Med. 54:746 (Nov.) 1959.

[3] Salisbury, P. F.: Timely versus delayed use of the artificial kidney, A.M.A. Arch. Int. Med. 101:690 (Apr.) 1958.

General Considerations

Before considering the indications as such, preliminary remarks regarding safety, expense, and general philosophy will be made.

Safety

It is our opinion that, with the basic knowledge of the technical aspects of the machine on one hand, and an understanding of the over-all problems of hemodynamics of the circulatory system on the other, the procedure is safe and effective in correcting uremia or other chemical abnormalities in the blood. The ultimate result depends upon the status of the patient's kidneys and other vital organs. In other words, the underlying medical or surgical disease may kill the patient but, in using the nephromime, the goal is to prevent chemical abnormalities from doing it first.

Expense

The average charge of $300-350 per dialysis, in the beginning, seemed excessive. When one considers the personnel involved, the material used, (coil, chemicals, solutions, medications, etc.), and laboratory determinations, the cost to the hospital is greater than the charge, the difference being assumed by the hospital. The total cost to the patient (and the hospital) of preventive or prophylactic daily dialysis could be staggering. In this instance, the use of a different dialyzer (such as the Collins-MacNeil type of nephromime) can reduce the cost substantially.

On the other hand, nondialyzed cases may incur heavy expenses resulting from prolonged hospitalization and complications such as infection. We have heard of a patient with acute tubular necrosis who was not dialyzed and who struggled through a period of rather fantastic diuresis, thereby incurring tremendous expense due to extended hospitalization. It is our opinion that the expense of the procedure should not be a serious consideration alongside of clear-cut indications for dialysis.

Philosophy Regarding the Use of the Nephromime

Generally speaking, authorities agree that dialysis is of value in cases of reversible renal disease and of limited or no value in the irreversible conditions. Often the diagnosis is not clear-cut because one cannot be absolutely certain of the diagnosis without renal biopsy. Thus, cases are divided into "potentially reversible" and "irreversible" categories. Yet, in an anuric or oliguric patient with potentially reversible disease, no two experts may agree as to when, if at all, dialysis should be performed.[4] In fact, this is the area of disagreement. It stems from differences in the basic philosophy regarding the procedure.

One group feels that with the improved management of today, cases of acute anuria seldom require dialysis. They speak of "conservative" management in contradistinction to the use of the nephromime. This expression certainly implies that the use of this machine is radical. However, its use has increased tremendously, and trained and experienced personnel are likewise more available. The term "conservative" has now outlived its usefulness and the ill effects of its use are now felt. The use of the nephromime and "radical" therapy have become synonymous in the minds of many physicians. They feel that the people who use this machine consider it a substitute for good medical therapy.

Nothing can be further from the truth. The nephromime is part of good medical therapy and its use depends upon the individual case and conditions involved. For example, we feel it is foolish and inexcusable to avoid or even delay use of the nephromime in a case of severe barbiturate intoxication. Others feel that cases of acute anuria should be dialyzed if there is clear-cut chemical and clinical evidence of uremic deterioration. Still others believe in dialysis before development of severe uremic symptoms,[5] and even daily, on a prophylactic basis.[6]

Indications

The cases in which the nephromime may be indicated can be divided into certain major categories:

I. Acute intoxications
II. Acute tubular necrosis
III. Primary renal diseases
IV. "Hepatorenal syndrome," (so-called)
V. Metabolic (diabetic) acidosis with renal insufficiency
VI. Iatrogenic fluid and electrolyte imbalance

Acute Intoxications

Acute intoxications include cases of poisoning by barbiturates, Doriden, bromides, salicylates, and other drugs.[7] Excluding nephrotoxic poisons, the prognosis depends mainly on dosage and duration

[4] (a) Salisbury.[3] (b) Franklin, S. S., and Merrill, J. P.: Medical Progress: Acute renal failure (concluded), New Engl. J. Med. 262: 761 (Apr. 14) 1960. (c) Kolff, W. J.: Dialysis in the treatment of uremia, Dept. Med. Surg., TB 10-97, V. A. Tech. Bull. Wash. 25, D. C., p. 11, 1954.

[5] (a) Salisbury.[3] (b) Kelemen, W. A., and Kolff, W. J.: Use of artificial kidney in the very young, the very old, and the very sick, J.A.M.A. 171:530 (Oct. 3) 1959. (c) Teschan, P. E., O'Brien, T. F., and Baxter, C. R.: Prophylactic daily hemodialysis in the treatment of acute renal failure, Surg. Forum 10:362, 1960. (d) Maher, and Broadbent.[2e] (e) Kiley, I. E., Powers, S. R., Jr., and Beebe, R. T.: Acute renal failure: eighty cases of renal tubular necrosis, New Engl. J. Med. 262:481 (Mar. 10) 1960.

[6] Teschan *et al.*[5e]

[7] Schreiner, G. E.: The role of hemodialysis (artificial kidney) in acute poisoning, A.M.A. Arch. Int. Med. 102:896 (Dec.) 1958.

TABLE 1.—*Diagnosis of Acute Tubular Necrosis*

A. PREDISPOSING FACTORS—usually various states associated with circulatory failure.

Medical:
- Nephrotoxins—carbon tetrachloride, mercury, ethylene glycol.
- Mismatched transfusions.
- Diabetic acidosis (unusual).
- Various conditions associated with circulatory insufficiency such as CVA, myocardial insufficiency, esophageal varices and hemorrhage, etc.

Obstetrical:
- Criminal abortions—mechanically or chemically induced.
- Ante-partum & post-partum hemorrhage—afibrinogenemia associated with abruptio placentae, amniotic fluid embolism, etc.

Surgical:
- Postoperative—especially vascular surgery.
- Burns.
- Trauma.

B. CLINICAL CRITERIA

Diminished volume of urine
- I.V. infusion 250 to 500 cc—caution.
- Vasopressin concentration test.

Urinary changes
- Specific gravity tends to be low.
- Osmolarity tends to be low.
- Urea low.
- Sodium elevated.

Blood urea elevation, progressive rise

of intoxication. We had nine cases of barbiturate intoxication with one death. The latter illustrated the importance of avoiding undue delay, since prolonged anoxia or circulatory collapse may lead to irreversible central nervous system damage. We have not encountered such a case. In one case associated with prolonged shock, acute tubular necrosis became one of the troublesome complications.

When clinical evidence points to drug intoxication, especially with a history of having had the drug prescribed or the finding of partially or completely emptied drug containers, preparations for dialysis should be initiated while studies are in progress. We feel that a patient in deep coma should be tracheotomized. Furthermore, it is felt that nothing is to be lost and much is to be gained by not waiting for the time-consuming qualitative and quantitative barbiturate determination. An adequate qualitative determination takes at least 45 minutes to one hour. Further complicating identification is the fact that more and more combinations of drugs are being used.

It is stated that dialysis is of limited value in poisoning by Seconal and other short-acting barbiturates because these drugs dialyze poorly.[4e] Schreiner points out the importance of dialyzing such cases and with this we agree. The Queen's Hospital Laboratory has followed barbiturate intoxications assiduously. In one instance, 930 mg. of Seconal was removed. This is equivalent to about ten 1½ grain capsules, an amount which unquestionably could and probably did spell the difference between life and death. This patient survived.

It is generally accepted that good nursing care is of paramount importance in comatose cases. While these cases are being brought out of coma by dialysis, good nursing care is assured because a team of physician (or physicians), nurse, and technician is in constant attendance.

The duration of dialysis has not been limited to six hours but is timed according to the response (or lack of response) of the patient. One case was dialyzed for 31 hours over a period of three days. Seventeen hours was the longest period for a single dialysis.

Acute Tubular Necrosis

Acute tubular necrosis is also referred to as acute hypoxic nephrosis, lower nephron nephrosis, or acute anuria. It is a complication of a wide variety of conditions including traumatic accidents, surgical procedures, burns, and innumerable medical and obstetrical conditions in which shock or circulatory collapse may occur. In this category might also be included nephrotoxic poisons such as mercury and others[7] (Table 1-A). There is a significant mortality associated with this condition, particularly in the older age groups and with associated trauma.[8] Although the condition is referred to as acute anuria, complete urinary suppression is not the usual situation. When such does occur, it is referred to as total or complete anuria and a more serious condition, renal cortical necrosis, should be considered.[9]

Early recognition of the condition is very important but sometimes difficult[10] (Table 1-B). Reduced volume of urinary output (oliguria) is one of the manifestations. Invariably, the question arises whether this represents dehydration or reduced blood volume, or some other cause of circulatory insufficiency, rather than acute tubular necrosis. A small intravenous infusion, up to 500 cc, will improve urinary output if low blood volume was at fault. A vasopressin concentration test may be used with caution.[11]

Changes in urinary composition occur. In a normal person, urea is the major contributor to the solute load and sodium excretion is practically nil, but this relationship is reversed in tubular

[8] Kiley *et al.*[5e]
[9] Wells, J. D., Margolin, E. G., and Gall, E. A.: Renal cortical necrosis—clinical and pathologic features in 21 cases, Am. J. Med. 29:257 (Aug.) 1960.
[10] Franklin, S. S., and Merrill, J. P.: Medical Progress: Acute renal failure, New Engl. J. Med. 262:711 (Apr. 7) 1960.
[11] Horne, S. F., and Morris, L. M.: Use of posterior pituitary extract (pituitrin) to measure renal function, Am. J. M. Sc. 213:68 (Jan.) 1947.

disease. Thus, the specific gravity and osmolarity of the urine tend to be low in the latter. Low solute concentration, however, does not necessarily indicate a severe renal lesion, since blood flow, glomerular filtration rate, urine flow and solute, and sodium excretion are decreased during and shortly after operations.[12] Impaired concentrating ability can be demonstrated in the postoperative state by the presence of low urine osmolarity, but this is transient in most instances.[12] A rise in BUN is not always a reliable gauge of tubular damage, because this can occur with dehydration or gastrointestinal bleeding; however, a progressive persistent rise is significant. The greater the increment, the more serious the disease, and the better the correlation with symptoms.[13]

At this point, after the condition is recognized, good medical management becomes paramount.[14] The patient should be managed with strictest attention to fluid intake. There is no excuse for the attitude that "the nephromime will get us out of trouble if we overload the patient." The pathophysiology involved is complex and does not lend itself readily to simplification.

A patient in anuria should be followed closely as to weight. There should be a weight loss from 0.2 to 0.5 kg daily.[4b] If not, the patient is probably accumulating an excess of fluid. Daily fluid intake should be limited to a basic maintenance figure of 400 cc to take care of insensible loss, with gastrointestinal, vascular, or renal losses to be replaced in addition.[15] Among other therapeutic measures, high-caloric low-protein intake[16] and prevention of infection are important.

The question of dialysis arises because chemical abnormalities develop. As the condition progresses, clinical symptoms may also appear. When should such a patient be placed on the nephromime? The chemical aberrations can be followed to indicate the progression and severity, or improvement of uremia. But it does not behoove us to be dogmatic, since chemical changes may not correlate with clinical findings (Table 2). Most clinicians feel that the latter are more reliable in indicating severe uremia.[17]

[12] Gullick, H. D., and Raisz, L. G.: Changes in renal concentrating ability associated with major surgical procedures, New Engl. J. Med. 262:1309 (June 30) 1960.

[13] (a) Kelemen, W. A., and Kolff, W. J.: An evaluation of the management of acute renal failure with dialysis, Arch. Int. Med. 102:871 (Dec.) 1958. (b) Goldring, W., Moderator; Chasis, H., Merrill, J. P., Riley, C. M., and Schreiner, G. E.: Panel meet. Oct. 15, 1958, N. Y. Acad. Med., Bull. N. Y. Acad. Med. 36:662 (Oct.) 1960.

[14] (a) Merrill,[2b] (b) Franklin and Merrill,[4b] (c) Kolff,[4c] (d) Kelemen, W. A., and Kolff, W. J.: Evaluation of dialysis in treatment of chronic renal failure: study of twenty-eight cases treated in one year, A.M.A. Arch. Int. Med. 106:608 (Nov.) 1960. (e) Swann, R. C., and Merrill, J. P.: Clinical course of acute renal failure, Medicine 32:215 (May) 1953. (f) Merrill, J. P.: The treatment of renal failure. Therapeutic principles in the management of acute and chronic uremia, New York, Grune, 1955.

[15] (a) Kiley *et al.*,[5e] (b) Franklin and Merrill.[4b]

[16] Kolff, W. J.: Forced high caloric, low protein diet and the treatment of uremia, Am. J. Med. 12:667 (June) 1952.

[17] (a) Salisbury,[3] (b) Franklin and Merrill,[4b] (c) Kelemen and Kolff.[13a]

TABLE 2.—*Immediate Indications for Dialysis in Uremia*

Biochemical:
K: 6.5 mEq. or more
BUN: 150 mgm/100 ml
CO_2: 12 mEq.
Clinical:
Mental changes, drowsiness, confusion
Excessive vomiting
Pulmonary edema
Pericardial friction

We have noted that perhaps more important than any single criterion is the basic philosophy of the clinician in charge of the case. This aspect has been covered above under general considerations. One case of severe crush injury in renal shutdown was treated with eight dialyses on consecutive days. This patient recovered from the renal shutdown only to succumb to infection by bacteria resistant to all antibiotics. Nevertheless, this case impressed us with the value of early and frequent dialysis, before the serious signs and symptoms of uremia appear. There is no reason why dialysis cannot be planned ahead of time instead of being reserved for complications. Frequently the latter occur at hours when personnel are not readily available. The delay which results may be to the detriment of the patient.

We cannot dismiss this aspect of the discussion without a word about the "diuretic phase." In a patient whose output has been a few cubic centimeters of urine, an increment of a hundred or more cubic centimeters is encouraging. It must be emphasized that the patient should be watched even more closely because uremic deterioration continues and preventable deaths can and do occur.[18] Actually, we do not consider the patient to be in the diuretic phase until he puts out sufficient urine to prevent the accumulation of the products of metabolism. Because the renal function improves only gradually, the volume required to accomplish this is between 1000 and 1500 cc. In other words, a patient with 800 cc urinary output should not be considered "out of the woods" if the nitrogenous products continue to accumulate and if chemically or clinically he continues to deteriorate.

Renal cortical necrosis is considered to be relatively uncommon, though the true incidence is difficult to determine.[19] In life, this can be suspected[9] but not definitely established without renal biopsies.[20] Without biopsies, this condition

[18] Swann and Merrill.[14f]

[19] Lauler, D. P., and Schreiner, G. E.: Bilateral renal cortical necrosis, Am. J. Med. 24:519 (Apr.) 1958.

[20] (a) Wells *et al.*,[9] (b) Lauler and Schreiner,[19] (c) Brun, C., and Raaschou, F.: Kidney biopsies, Am. J. Med. 24:676 (May) 1958, (d) Boucot, N. G., Guild, W. R., and Merrill, J. P.: Bilateral renocortical necrosis with recovery: report of a case, New Engl. J. Med. 257:416 (Aug. 29) 1957.

is likely to be classified as acute tubular necrosis. If all cases of acute anuria were to be biopsied, more cases of this condition would probably be found. Sheehan and Moore[21] in a series of autopsies showed that partial or patchy destruction of the renal cortex can occur. While the course in this condition is considered to be rapid and fatal, and while only a few cases of recovery have been reported,[22] the concept of partial involvement of the renal cortex would appear to justify the inclusion of such an entity among the potentially reversible group which might be helped by dialysis.

Primary Renal Diseases

There were 543 autopsied cases at The Queen's Hospital in a two-year period, 1958 to 1960, and of these 106 were newborns or stillbirths. The majority of autopsied cases were in the higher age group, with nearly 40% showing arterial and arteriolar types of vascular involvement. Almost two-thirds showed some type of renal pathology. Multiple diseases of the kidney occurred in 69 (13%). Renal failure occurred in 84. With advancing age, aggressive surgery, including procedures on the cardiovascular system, causes secondary renal involvement and failure to assume an important place. We had 11 cases in this category and all were classed pathologically as acute tubular necrosis. Failure to anticipate and recognize this disorder resulted in excessive administration of fluid and blood in many of these cases, with resulting cardiovascular failure and fluid and electrolyte imbalance.

Acute glomerulonephritis is quite uncommon. The one case encountered at The Queen's Hospital was diagnosed microscopically after autopsy in a patient who died from multiple unrelated causes. Dialysis has been advocated as part of the well-planned management of these cases,[23] but it is seldom necessary except when overhydration or over-administration of saline has occurred.[13b] It is said to be of doubtful value in subacute glomerulonephritis. We had no case in this category. In chronic glomerulonephritis, the outlook is generally poor, as it is in most cases of chronic uremia.[24] Such patients sometimes become more or less stabilized at a new high level and remain so until an intercurrent obstetrical, surgical, or medical condition brings about deterioration.[24a] Dialysis may help these cases. Certainly, these patients should be dialyzed preoperatively. In a long standing case of progressively deteriorating chronic nephritis, one should not expect too much, and certainly no optimistic prognosis should be made to the family. In our ten chronic uremics dialyzed, the improvement, while definite and occasionally dramatic, was temporary. Whether or not this justifies the cost is, we believe, an individual philosophical question. One family was grateful for the opportunity of having their previously comatose mother home in reasonably good condition to enjoy their last Christmas and New Year holidays together.

Keleman and Kolff found dialysis worthwhile in 39% of their dialyzed cases.[24b] Of the chronic renal conditions, cases of polycystic disease have had the best results.[24c] This was illustrated to us in one such patient who had come to Hawaii as a "dying wish." After two dialyses, he was able to enjoy the remaining days of his stay in Hawaii and when last heard from several months later, he had returned to his occupation in New York in apparent good health.

We have employed multiple dialyses in preference to a single procedure in chronic cases. In one patient, after a short period of marked improvement, convulsive seizures and unconsciousness suddenly occurred. After three days of sedation, the patient awoke without neurologic sequelae. This case made us wonder if rapid reversion to normal blood chemistry was not responsible for the episode. Thus, we have shortened the first run to three hours. We find, however, that we still remove up to 90 g of urea during this short period.

The total quantity of urea removed, we concede, is not in itself a significant figure. It varies widely from patient to patient. For lack of a better yardstick, however, we have utilized it as a rough measure of the effectiveness of the machine. For what it is worth, we have noted that with shorter periods of dialysis, the patient has less discomfort and muscle-aching afterward and is more willing to return for repeat dialysis. Certainly, here as in other indications, a few hours of dialysis are equivalent to many days or weeks of difficult management.[24b]

Before denying a patient an effective therapeutic measure, it is important to be sure of the diagnosis, and this is where renal biopsies are particularly indicated. Discrepancy between the clinical and pathological diagnoses occurs often enough to fully justify this diagnostic procedure, not only here but in other renal conditions.[20c] Where question of diagnosis still exists, the patient should be given the benefit of the doubt.

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[21] Sheehan, H. L., and Moore, H. C.: Renal cortical necrosis and kidney of concealed accidental hemorrhage, Springfield, Ill., Thomas, 1953.

[22] (a) Lauler and Schreiner,[19] (b) Boucot *et al.*[20d]

[23] Anderson, A., and Kolff, W. J.: Artificial kidney in the treatment of uremia associated with acute glomerulonephritis (with a note on regional heparinization), Ann. Int. Med. 51:476 (Sept.) 1959.

[24] (a) Goldner, F., Gordon, G. L., and Danzig, L. E.: Use of artificial kidney in chronic renal disease, A.M.A. Arch. Int. Med. 93:61 (Jan.) 1954. (b) Kelemen, W. A., and Kolff, W. J.: Evaluation of dialysis in treatment of chronic renal failure: study of twenty-eight cases treated in one year, A.M.A. Arch. Int. Med. 106:608 (Nov.) 1960. (c) Nakamoto, S., and Kolff, W. J.: Chronic uremia due to polycystic renal disease treated with the artificial kidney, A.M.A. Arch. Int. Med. 101:921 (May) 1958.

Hepatorenal Syndrome

Some deny the existence of the so-called "hepatorenal syndrome." Nevertheless, there is a group of cases where renal and hepatic insufficiency co-exist. The former possibly results from circulatory failure, reduced glomerular filtration rate and possibly pressure on the hepatic vein by ascites associated with advanced hepatic disease such as cirrhosis. In one study,[25] biopsies revealed changes similar to acute tubular necrosis. The renal changes might therefore be considered reversible. There are oliguria and rising blood urea nitrogen as well as ammonia intoxication.

We had one case in this category who did not benefit from dialysis. However, many feel that dialysis in these cases should be considered to prevent death from renal insufficiency.

In hepatic insufficiency, dialysis is seldom indicated except in those cases associated with massive gastro-intestinal bleeding and rapidly developing ammonia intoxication.[26] The outlook in this group of cases, generally speaking, is poor.

Metabolic (Diabetic) Acidosis with Renal Insufficiency

Renal shutdown may co-exist with diabetic acidosis and preclude correction of the electrolyte imbalance by parenteral fluid therapy. Dialysis would then be imperative.[27] Renal insufficiency associated with intercapillary glomerulosclerosis is included in the category of chronic uremias. Our case showed improvement lasting only about one week.

Iatrogenic Fluid and Electrolyte Imbalance

In the past decade, with rapid strides in the understanding of fluid and electrolyte balance, the management of cases of anuria has likewise improved. It is the experience of most centers that referrals of grossly mismanaged cases have decreased substantially. However, overhydration, overdose of potentially lethal drugs, and unexpected electrolyte imbalance do occur, and dialysis may be a life-saving procedure in these situations.

We had a case with hyperkalemia (iatrogenic) and congestive failure due to rheumatic heart disease. We feel that dialysis in this case was life-saving. She subsequently developed renal shutdown which even continued nine days postdialysis. Repeat dialysis was not performed because the patient was doing "exceptionally well."

Dialysis has recently been advocated for correction of fluid and electrolyte imbalance in intractable cases of congestive heart failure.[28]

Conclusion and Summary

The nephromime is no longer merely a research tool and should be considered a valuable part of the medical and surgical therapeutic armamentarium. Judging from our series of cases, more than one such unit in an area such as Hawaii is probably not necessary. There is little doubt as to the importance of that single unit, however. Without it the outcome in many cases, particularly the intoxications, would probably have been fatal. Operated by properly trained personnel, the machine is safe and effective.

A major problem has been to determine the indications for the use of this machine. We have tried to present our view in the light of our experience and that of others in this field. Renal failure per se is not an indication for the use of the machine.

In general, patients with reversible renal involvement are ideal for dialysis. In this group might be placed the acute intoxications. Here the avoidance of delay is of paramount importance. In other conditions, since it is not possible to be certain clinically, the patients are classified as either "potentially reversible" or "irreversible." In the former group, we favor earlier and more frequent dialysis.

The nephromime is not a substitute for, but an integral part of, good medical therapy.

Acknowledgements

We are grateful to Dr. W. J. Kolff and his staff at the Cleveland Clinic, Cleveland, Ohio, and to Dr. W. A. Kelemen, formerly of the Cleveland Clinic, for their invaluable assistance and advice which made the setting up of the nephromime at The Queen's Hospital a less formidable task.

It would not be possible to acknowledge all who have helped us locally, for we have drawn freely upon the personnel from the different departments of The Queen's Hospital and from the attending medical and surgical staff members. However, much credit is due to two capable physicians, Drs. Hyman Fisher and Emiko Sakurai Hirschy, formerly residents in internal medicine and clinical pathology, respectively. Their attention to countless details has been in evidence with each dialysis.

[25] Lassen, L. A., and Thomsen, A. C.: The pathogenesis of the hepatorenal syndrome, Acta med. Scandinav. 160:165 (Mar. 7) 1958.

[26] Kiley, J. E., Pender, J. C., Welch, H. F., and Welch, C. S.: Ammonia intoxication treated by hemodialysis, New Engl. J. Med. 259:1156 (Dec. 11) 1958.

[27] Aoyama, S., and Kolff, W. J.: Severe diabetic acidosis treated with the artificial kidney: report of a case complicated with acute renal failure, J.A.M.A. 166:9 (Jan. 4) 1958.

[28] Lemmon, W. M., Hirose, T., O'Connor, R. A., and Bailey, C. P.: Congestive heart failure—relief by renal dialysis, J.A.M.A. 174:54 (Dec. 24) 1960.

An internist familiar with the nephromime reports on 25 cases in which it was used

Experiences with the Artificial Kidney at The Queen's Hospital

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THE KOLFF disposable twin-coil kidney[1] was first used at The Queen's Hospital on June 10, 1958. Through December, 1960, 40 extracorporeal hemodialyses were carried out on 25 patients (Table 1). Pertinent laboratory data are tabulated (Tables 2 and 3). From the technical standpoint, it should be emphasized that the "kidney" was found to be simple, safe, and effective.

Simple

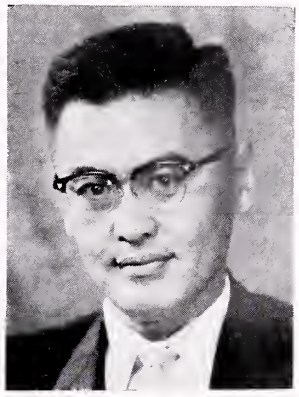
No complicated manipulation of electrolytes is necessary. The patient's blood passing through the coils equilibrates with a voluminous bath, the electrolyte composition of which approximates that of normal extracellular fluid. In this respect, the "kidney" is more like a placenta than a kidney. Usually, only two things are varied: K^+ may be kept low in hyperkalemia; invert sugar may be increased for several reasons: (1) to counteract the osmotic pull of urea, (2) to provide high glucose concentration to combat endogenous protein catabolism, or (3) to remove water osmotically.

Safe

No trouble with volume shifts has occurred. The blood pump is started slowly and raised gradually to the normal speed. Blood pressure fluctuations have been minimal at the beginning of the "run." Under usual operating conditions, the coils hold a constant volume of blood.[2] The flow rate is 200 ml/min, so free breaks in the main lines, e.g., separation at connections, could be disastrous. But, for the same reason, rapid transfusion is possible. A slow leak from the coils would not necessarily be dangerous.

Effective

As noted in Table 2, large amounts of urea are removed. The usual run lasts six hours with bath changes every two hours. Some patients with chronic renal failure are dialyzed twice, two days apart, the first dialysis lasting three hours with a bath change at 1½ hours. Even with the shorter run, as much or more total urea is removed because of the initial high urea concentrations. Apparently the "kidney" removes urea from the blood faster than the tissues can release it to the blood. Considerably less urea is removed with each successive bath. Because of diminishing returns, the standard run has come to be limited to six hours. The BUN rises immediately after cessation of dialysis. Therefore, in chronic uremics, urea is allowed to re-equilibrate, then a second run of six hours is performed. In highly catabolic patients, longer runs may be done, with successive baths continuing to yield much urea.[3] If the rate of shift of urea is taken as 100, that of K^+ is 100, HCO_3^- 55, and glucose 40.[4]



Bauer

DR. HORIO

With drug poisoning cases, bath changes are necessary only every three hours. However, dialysis is maintained as long as technically possible

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[1] Kolff, W. J., Watschinger, B., and Vertes, V.: Results in patients treated with the coil kidney (disposable dialyzing unit), J.A.M.A. 161:1433 (Aug. 11) 1956.

[2] Tu, W. H.: A study of hemodynamics of the twin coil artificial kidney. The relationship of perfusion rate and blood volume within the coil, Trans. Am. Soc. for Artif. Int. Organs 6:2, 1960.

[3] Schreiner, G. E.: Personal communication.

[4] Kolff, W. J.: The artificial kidney—past, present, and future, Circulation 15:285 (Feb.) 1957.

TABLE 1.—*Types of cases.*

	CASE NO.	NO. OF RUNS	OLIGURIA (less than 400 ml/24 hrs)	FEVER (100° or more immed. after dialysis)	SURVIVAL AFTER FIRST DIALYSIS	AUTOPSY
Acute uremia, 5						
Surgical, 2						
Post-op, repair of dissecting aneurysm	9	3	*	none	5 days	yes
Severe crush injuries	22	8	*	*	5½ weeks	yes
Medical, 3						
Congestive heart failure 2° pneumonia	15	1	none	10 days*	3 weeks	no
Septicemia 2° E. coli pyelonephritis	18	1	none	10 days*	living	
Hepato-renal syndrome	11	1	none	till death	5 days	no
Electrolyte imbalance, iatrogenic	14	1	*	2 days	living	
Chronic uremia, 10						
Chronic glomerulonephritis, 5	2	1	none	none	5½ weeks	yes
	10	2	none	none	2 weeks	no
	16	1	none	2 days	2 weeks	no
	17	1	none	only eve of dialysis	4⅔ months	no
	21	1	relative decr, 2 days	1 day	2 months	yes
Chronic pyelonephritis	1	1	2 days	1 day	5 weeks	yes
Chronic glomerulo- and pyelonephritis	6	2	none	none	3½ months	yes
Chronic, unspecified	5	2	none	none	few weeks	no
Kimmelstiel-Wilson and arteriolar nephrosclerosis	12	1	4 days	none	4½ weeks	yes
Congenital polycystic	7	2	none	2 days after 2nd run	living	
Poisonings						
Barbiturates, 9	3	1	2 days	7 days	living	
	4	1	*	till death	2½ days	Coroner's
	8	1	none	4 days	living	
	13	1	none	3 days 2 more days, slight	living	
	19	1	none	2 days	living	
	20	1	none	none	living	
	23	3	*	3 days (dialyzed each day)	living	
	24	1	none	½ day	living	
	25	1	1 day	4 days	living	

* from primary condition.

or until the patient shows signs of definite improvement.

Administrative Problems

The project was initiated by Paul Y. Tamura, M.D., of The Queen's Hospital, Department of Laboratories, with the help of medical residents assigned to that service. Dr. Tamura helped to monitor the earlier cases but could not be expected to take over the clinician's role. Opportunity to become familiar with the technique has been available to all physicians on the staff.

Originally, a consultation with a member of the Artificial Kidney Committee was required to decide on dialysis of a given patient. Practically all of the proposed cases were chronic ones, and after the first two such cases, very few others were approved. Eventually the attitude against running chronic cases was relaxed and medical residents were able to become proficient in supervising dialyses. Later, we began to dialyze patients without seeking approval of a member of the Artificial Kidney Committee. At times of shortage of qualified residents, it was feared that this bypassing of proper referrals would leave the technician in the position of being forced to assume undue responsibility. Furthermore, the personnel of the Department of Laboratories often found themselves being asked to make clinical decisions regarding the feasibility of dialysis in a given case.

The Department of Laboratories has referred all problems to qualified clinicians. It was at times awkward to insist on a consultation when only one clinician was thoroughly familiar with technical aspects, but now, more physicians are showing interest in learning the procedure.

Cannulations

In an elective dialysis, cut-downs should be made about one hour previously in the operating

TABLE 2.—*Laboratory data.*

CASE NO.	BUN MG%		UREA REMOVED, IN GRAMS		CO_2 mM/1		K^+ mEq/1	
	before	after	total	per bath	before	after	before	after
1	195	38	73	(62.3, 6.4, 4.3)	12.7	26.2	4.3	4.8
2	206	26.5	102.8	(57.8, 30.6, 15.4)	<9	24.4	3.6	6 sl hemolyzed
5	185	89.5	85.5	(46.2, 39.6)*	14	25.3	5.1	3.9
	118	40	77.9	(33.8, 27, 17.1)	19	25.7	5	5.5
6	225	73.5	83.7	(36.4, 26.3, 21)*	<10	13.5	5.2	
	112.5	26.5	58	(29.7, 18.2, 10.1)	<10	24.8	3.5	4.6
7	219	142	80.7	(49.9, 30.8)*	<9	28.4	4.9	3.9
	150	51.5	101	(46.2, 30.8, 24)	11.3	22.1	5.2	4.6
9	142	65.5	80	(41.1, 25.7, 13.3)	14	20.8	3.2	4.8
	179	108	66.1	(35.3, 21.8, 9)	19	21.7	7.4	5.4
	165	68	96.3	(34.9, 34.2, 27.2)	14.9	24.4	8.1	5
10	233	116.5	96.1	(51.4, 44.7)*	16	22.4	3.4	3.8
	128	52	88.6	(34.9, 28.7, 25)	14.5	24.8	4	4.3
11	87	45.5	72	(25, 21.6, 15.4)	20.8	20.8	4.5	5.4
12	118.5	33.5	68.5	(30.2, 22.5, 15.8)	11.3	16.7	5.1	4.8
14	70.5	17.5	36.2	(18.4, 10.5, 7.3)	13	23	9.2	4.9
15	248	70	107	(40.7, 38.9, 27.4)	11.7	19	6.8	4.6
16	137	48.5	95	(37.2, 32.1, 25.7)	14.5	22.1	4.1	4.5
17	88	27.4	55.8	(19, 21.2, 15.6)	13.5	23.5	4.7	4.6
18	103	14.5	57	(21.2, 20.8, 15)	<9	27.1	4.9	5.6
21	205	97.5	106.1	(34.2, 36, 36)	10.8	18.5	5.9	4.6
22	81	53.5	51.6	(19.5, 16.1, 16.1)	15.8	17.6	5.9	4.7
	118.5	75	77.7	(31.7, 27.8, 16.1)	14.9	17.2	5.2	4.7
	123	100	62.2	(25.5, 26.1, 10.7**)	14	16.3	5.5	4.9
	156	109.5	112	(29.7, 30.6, 26.1, 26.8)†	10	17.6	5.7	no data
	174	103	92	(34.9, 28, 28.9)	<9	21.7	6.2	4.5
	187.5	123	106.4	(no data)‡	15.4	19	5.4	4.4
	145	112.5	91	(32.1, 34.2, 24.6)	12.7	20.3	6	5
	164	105	94	(27.6, 28.9, 37.5)	13.8	19.4	6.3	3.7

* 3 hour run, 2 baths of 1½ hours each, or 3 baths of 1 hour each.
** Last 2 hour run on 1 coil.
† Extra 2 hour run.
‡ 7 hour total run.

room so that troublesome and messy oozing, as a result of subsequent heparinization, will be minimal. If, as may happen under emergency conditions, an adequate vessel is not located on initial exposure, a break in sterile technique often occurs in changing of operative sites. Even with strict care, when cannulas are kept in place retained for prolonged, multiple dialyses, cut-down sites usually become infected.[5]

In the Queen's Hospital procedure, the blood is usually removed from the femoral vein and returned to the patient via the brachial vein. Our only difficulty has been with the return flow. Relative obstruction has resulted when the return cannula has been too small, or when clotting has occurred within the cannula during repeated dialyses. Resultant high outflow pressures necessitate decreasing blood flow rate, cause unnecessary ultrafiltration, and increase danger of coil rupture. In two cases, cannulation of another vessel was necessary. The external jugular vein was resorted to in one, with increased danger of air embolism, and the remaining femoral vein in the other, thus using up a valuable vessel which might have been needed should further dialysis have been necessary.

Before blood pumps were available, the blood ran from the patient's artery back to a vein. Ultrafiltration was not possible. An artery can still be used, and may even be preferable. In one case in which an artery was cannulated, the blood flow was so vigorous that the tubing had to be clamped down proximal to the heparin drip. The patient's blood pressure alone is not sufficient to drive the blood through the twin coils of the "kidney." Between runs in multiple dialyses, the arterial and venous cannulas can be joined with a flow reducer, creating a controlled arteriovenous fistula and al-

[5] Teschan, P. E., Baxter, C. R., O'Brien, T. F., Freyhof, J. N., and Hall, W. H.: Prophylactic hemodialysis in the treatment of acute renal failure, Ann. Int. Med. 53:992 (Nov.) 1960.

lowing the cannulas to remain patent.[6] Even without this special technique, the blood has less tendency to clot in an arterial than in a venous cannula, probably because of continued pulsatile motion within the former. Moreover, an artery that has been used once can be used again proximal to the previous site, since the lumen remains patent.

Despite mechanical buffeting of the red blood cells, hemolysis has not been clinically apparent.

Tracheostomy

With patients in severely depressed states, it is advisable to perform an elective tracheotomy in the operating room, together with the cannulations, rather than later as an emergency procedure. Tracheobronchial toilet is thus facilitated. Unexpected apnea is more readily handled. Physiologic dead space is reduced and Cheyne-Stokes phenomena are lessened or obviated. In an emergency, the surgeon is under a handicap in our crowded kidney room, since instruments are limited to the "pack," lighting is comparatively poor, and bleeding is increased in a heparinized patient. The anesthesiologist is handicapped trying to work through the bars of the bed frame at the head of the bed.

Anticoagulation

Heparin is dripped into the blood as it goes into the "kidney." Clotting time of the blood returning to the patient is maintained at 20-30 minutes to prevent clotting within the coils. The total amount of heparin used has been kept down to 100-150 mg in the usual six-hour run. Eight successive dialyses in a severely injured patient were carried out without trouble from bleeding (case 22). Methods of infusing heparin into the blood entering the "kidney" and protamine into the blood leaving the "kidney" have been described.[5, 7]

Management During Dialyses

Obligatory ultrafiltration may approximate 300 ml/hour, resulting in dehydration with two to six pounds' weight loss during dialysis if fluids are not replaced.[8] In edematous states, if the pressure of the flow leaving the "kidney" is increased to 250 mm Hg, the ultrafiltrate increases to 700 ml/hour, resulting in six to eight pounds' weight loss.[8]

For mild hypotension, small increments of whole blood, 50 ml at a time, may be tried, especially if the patient is anemic or if blood has been oozing from the cut-downs and tracheostomy. The usual vasopressors, metaraminol (Aramine) or levarterenol (Levophed), may be given. For hypertension, hydralazine (Apresoline), pentolinium (Ansolysen), and promazine (Sparine) have been used. Diphenhydramine (Benadryl) and promethazine (Phenergan) have been given for restlessness. Chlorpromazine (Thorazine) and prochlorperazine (Compazine) have been tried for nausea. Unexplained trembling of the extremities resembling chills is occasionally seen early in dialysis. This has usually subsided gradually within a half hour or so.

Post-dialysis Oliguria and Fever

Worrisome oliguria occurred in several patients, both with and without primary renal disease. This has been previously noted, but its origin remains obscure.[4, 8] Unexplained fever was not uncommon and has also been noted by others.[1, 10]

Selection of Cases

Chronic Cases

If a case of chronic renal disease has been followed fairly carefully, and the natural course of the disease is apparent, few internists would propose dialysis. Dialysis should be tried if some complication such as intercurrent infection, excessive vomiting, or other metabolic disturbance is superimposed to a critical degree on existing, more or less stabilized, chronic renal disease.

Critical cases that have had no preceding medical management, once rectified by medical measures with or without dialysis, may be able to carry on for considerable periods. A good renal biopsy specimen may greatly influence decision as to dialysis. "In chronic uremia, a single dialysis may break the spell of continuous vomiting and misery. Six hours of dialysis may be the equivalent of six weeks of difficult, frustrating medical management."[4] Certainly, futile medical therapeutic exercises based on repeated, expensive laboratory tests in known hopeless cases cannot be considered to represent good clinical judgment. It is not easy to predict the duration of improvement after dialysis in chronic cases. Rarely, a surprising relatively long survival results. Nakamoto and Kolff had better than usual survival in a small series of cases in severe or apparently terminal uremia due to polycystic renal disease.[11]

[6] Quinton, W., Dillard, D., and Scribner, B. H.: Cannulation of blood vessels for prolonged hemodialysis, Trans. Am. Soc. for Artif. Int. Organs 6:104, 1960.

[7] Anderson, A., and Kolff, W. J.: Artificial kidney in the treatment of uremia associated with acute glomerulonephritis (with a note on regional heparinization), Ann. Int. Med. 51:476 (Sep.) 1959.

[8] Travenol Laboratories, Inc.: Instruction leaflet with coil dialyzing unit.

[9] Kelemen, W. A., and Kolff, W. J.: Evaluation of dialysis in the treatment of chronic renal failure, A.M.A. Arch. Int. Med. 5:608 (Nov.) 1960.

[10] Kiley, J. E., Powers, S. R., Jr., and Beebe, R. T.: Acute renal failure, N. Eng. J. Med. 262:481 (Mar. 10) 1960.

[11] Nakamoto, S., and Kolff, W. J.: Chronic uremia due to polycystic renal disease treated with the artificial kidney, A.M.A. Arch. Int. Med. 101:921 (May) 1958.

When the "kidney" has not been used for some time and a new group of residents are eager for experience, chronic cases might be dialyzed that otherwise would not. Socio-economic factors cannot be ignored: e.g., a business man may need time to get his affairs in order, or a family of means may desire any prolongation of life, with expenses not to be considered.

Acute Uremia

The chief problem is early recognition so that patients are not "drowned" initially. Laboratory tests on the urine may warn of this by showing decreased volume, isosthenuria, osmolarity approaching plasma values, inability to conserve sodium (usually over 30 mEq/l), or inability to excrete urea so that the ratio of urine urea to blood urea is less than ten.[12] Acute renal shutdown must be anticipated on clinical grounds. Most important to consider is the fact that dialysis is no substitute for good medical management.

The concept of prophylactic hemodialysis has been pioneered by Teschan, the principle being to keep patients out of clinical uremia with its attendant morbidity.[5] We tried this in one case (#22) with apparent technical success.

Poisonings

Our most gratifying experiences have been with cases of suicidal barbiturate ingestion. Our indications for dialysis have been among those enumerated by Schreiner:[13a]

(a) Deteriorating clinical condition: vasomotor instability and shock, cyanosis and respiratory arrest, severe depression with areflexia, etc.

(b) Known ingestion of a potentially fatal amount: three grams for short acting ones, five grams for long acting ones.

Schreiner mentions blood barbiturate levels. Unfortunately, quantitative blood levels have been of no practical help to us, as the determinations could not be done "stat" in our laboratory. It was of interest later to correlate the blood values with the alleged dose and the clinical picture before and after dialysis.

Another indication would have been the existence or the development of any significant medical complication increasing the hazards of prolonged coma. We had no cases in this category.

The "kidney" is more effective in dialyzing long-acting barbiturates, but short-acting ones are also dialyzable to some extent, viz., phenobarbital 40% recoverable, amobarbital 35%, pentobarbital 20%.[13b]

Good nursing, equal to post-surgical care, is most essential. During dialysis, clinical observation of a fluctuating level of depression strongly suggests removal of the drug from the blood and tissues where it is acting, and equilibration in turn with a depot or reservoir. This phenomenon has been stressed by Schreiner in his case reports.[13] Early dialysis, before the depots are saturated, seems logical. The clinical response of the patient determines the length of run. Schreiner mentions a 31-hour run on a Doriden case.[3] We had runs as long as 16 hours (case 23) and 12 hours (case 25).

Case Summaries

#1 46, f.

Chronic pyelonephritis, terminal, with azotemia, hypertension, nausea, and vomiting. After dialysis, clinical improvement was striking (felt "best in six months") but maintained for only a week.

Comment: First actual run on kidney. No preliminary animal trials deemed necessary as Dr. Tamura already had sufficient clinical experience elsewhere. Unqualified technical success, as expected.

#2 10, m.

Three year history of glomerulonephritis. In and out of hospital the first year with nephrotic syndrome. Azotemic with acidosis, anemia, hypertension and congestive heart failure; on digitalis. After dialysis, clinical improvement lasted seven to ten days.

#3, #4, #8, #13, #19, #20, #23, #24, #25 Barbiturate cases; see below.

#5 53, m.

Five year history of renal disease with hypertension. Diabetic for five years; on 20 units of insulin daily. Worked till two months before admission. Uremic syndrome. Dialyzed twice, two days apart. First run, three hours. During second run, Apresoline given for slight rise in BP from 150-160/90-100 to 180-190/100. No cooperation with medical regimen afterwards. Deteriorated rapidly and died.

#6 52, f.

Chronic pyelonephritis. Right nephrectomy ten years before for nonfunctioning hydronephrotic kidney. For three years, pyuria, hematuria, azotemia. Patient deeply comatose and hyperventilating. Dialyzed twice, two days apart. Convulsions two days after second dialysis though no rise in BP. Resultant right hemiparesis cleared in slightly over one month. Two months later, BUN 91 mg%, but anemic, PCV 15%. At 2½ months, BUN 150 mg%. Died at 3½ months.

Comment: Clinical result far better than expected.

[12] Perlmutter, M., Grossman, S. L., Rothenberg, S., and Dobkin, G.: Urine-serum urine nitrogen ratio, J.A.M.A. 170:1533 (July 25) 1959.

[13a] Schreiner, G. E.: The role of hemodialysis (artificial kidney) in acute poisoning, A.M.A. Arch. Int. Med. 102:896 (Dec.) 1958.

[13b] Berman, L. B., Jeghers, H. J., Schreiner, G. E., and Pallotta, A. J.: Hemodialysis, an effective therapy for acute barbiturate poisoning, J.A.M.A. 161:820 (June 30) 1956.

#7 40, m.

Congenital polycystic kidneys, diagnosis based on family history (father, brother, sister, cousin). Had had numerous bouts of gross hematuria. Gradual progression of clinical uremia over a four-month period. Dialyzed twice, two days apart. Right after second run, rise in BP from 140/80-90 to 180/100-108, treated by IM Apresoline. Hallucinated for one day, six days after second run.

Comment: Nakamoto and Kolff[11] report on 13 patients over a five-year period (1952-57), eight severely ill and dialyzed 14 times, two having three dialyses. Of the eight, four were restored to from several months to a year of useful life. They were surprised to find that after dialysis, arterial blood pressure decreased significantly and remained so for at least three weeks in all eight patients.

#9 54, m.

Repair of dissecting aneurysm of aorta with postoperative acute renal failure. Decrease in urinary output after surgery. BP 110-130/70-80. No response to 500 ml of 5% dextrose/water IV in one-half hour. Fluids immediately restricted. Dialyzed three times starting on fourth postoperative day. Second run, two days after first, stopped at 3½ hours because of pulmonary edema. Had received two units of blood (less 200 ml loss from cut-down). Gained 2½ lbs. Digitalized; phlebotomy 350 ml. Next day, third run. Lost 3½ lbs. and seemed less edematous the following morning but later that day, respirations became shallow and irregular, and patient expired. Autopsy revealed patient could perhaps have been saved with further dialyses.

Comment: Reported results are poor for anuria complicating aortic surgery. Recent series, Kiley *et al.*,[10] saved only one out of 12. Procaine infiltration around the renal arteries has been recommended to forestall the development of anuria. In this case, ultrafiltration could probably have been used more. Previous experience with pushing ultrafiltration to the limit was lacking. It may be mentioned here that the usual empiric management of fluid balance during dialyses resulted occasionally in marked disparities from clinical estimates when actually measured.[14]

#10 30, m.

Two-year history of rapidly progressive glomerulonephritis. Had nephrotic features early in course. Digitalized previously for congestive failure. Now azotemic, acidotic, and hypertensive. Two runs, eight days apart, first for three hours. Good relief of pulmonary edema with first run. Basal rales cleared. No clinical improvement after second, though chemical improvement. Died six days later.

#11 58, f.

Diagnostic problem, most likely hepato-renal syndrome. Known hypertensive, OK till 2½ weeks before admission. Minor surgery was followed by anorexia, dark urine, congestive heart failure. On examination, jaundice, ascites, enlarged liver with abnormal liver function tests. Dialyzed; lost 4½ lbs. but no clinical improvement. Ammonia nitrogen levels: before, 0.31 mg%; after, 0.46. Progressive downhill course and died five days after run.

#12 78, f.

Hypertensive cardiovascular disease with congestive heart failure and coronary insufficiency. Diabetes mellitus. Nocturnal dyspnea and pedal edema. Became oliguric; ascribed to possible diabetic glomerulosclerosis. Lost only ¾ lbs. with dialysis. Improvement lasted one week, then gradually deteriorated with death at 4½ weeks.

#14 49, f.

Rheumatic fever at age 12. Mitral valvulotomy three years before. Gastrectomy and cholecystectomy one year later. Acute flu syndrome five days before admission causing congestive heart failure. Apparently responded to therapy: Thiomerin 2 ml, Naturetin (benzydroflumethiazide) 5 mg, KCl 3 g., all daily. From second hospital day, Furadantin for pyuria. On ninth hospital day, temperature spiked to 103.8° with possible drug rash. On tenth hospital day, shock with BP 80/0; pulse 36, regular; ECG, no P waves, peaked T waves; K^+ 7.5 mEq/l, Na^+ 110, Cl^- 93, CO_2 10.8. Intravenous 5% NaCl and other solutions yielded only 5 ml urine. Dialyzed on eleventh hospital day to correct electrolyte imbalance and treat edema. Had gained 13½ lbs. in two days with peripheral and facial edema; lost six lbs. during dialysis. Oliguria due to shock lasted 11 days.

#15 70, m.

In St. Francis Hospital five days with three-week history of right lower chest pain and cough (pneumonia?), weight loss, and weakness. No high fever. Became more dyspneic. Digitalized on third hospital day. On fourth day, sticky black stool with BP 110/70 falling to 90/50. On fifth day, BUN 160 mg%, K^+ 7.6 mEq/l, but no clinical evidence of hyperkalemia. Originally, good urinary output, adequate S.G. (1.023-26), proteinuria 1-2+. Possibly dehydrated. Transferred to The Queen's Hospital for dialysis, critically ill and comatose, BUN 248 mg%. Fell to 70 with little rebound after dialysis; urinary output good and progressively increasing. Up eating after two days. Transferred to Leahi Hospital on tenth day after dialysis because of atypical AFB on sputum culture. Died 11 days later unexpectedly, though had chest pain for two days.

#16 51, m.

Proteinuria for 30 years. Gout for three years. Malaise and weakness for two weeks. Emesis three days. Died two weeks after dialysis with uremia and congestive heart failure.

#17 44, f.

Delivered; no complications. Five weeks later, fever. Admitted three weeks later to Kuakini Hospital with chills, backache. Treated with Aureomycin and Kanamycin. Six days after admission, BUN 124 mg%, creatinine 7 mg%, K^+ 5.b mEq/l, CO_2 27 mM/l. Gradually became lethargic and comatose. Urinary output good; seven days after admission, 1500 ml. All urines, S.G. 1.006-10. Transferred to The Queen's Hospital after eight days, for dialysis. Awake the day after dialysis. Urine volumes adequate after dialysis, 700 ml, 900 ml, then 1700-2700 ml with S.G. 1.010-12, yet BUN rose steadily to maximum of 85 mg% eight days after dialysis. Six days after dialysis, tinnitus. Spiking fever subsided ten days after dialysis.

[14] Andres, B. F., Murphy, J. P., and Zipf, R. E.: Changes in blood volume during use of artificial kidney, J.A.M.A. 170:2167 (Aug. 29) 1959.

TABLE 3.—*Barbiturate poisoning cases.*

CASE NO.	TYPE	AMOUNT INGESTED IN GRAMS	HOURS AFTER INGESTION SEEN	HOURS AFTER INGESTION DIALYZED	HOURS OF DIALYSIS	BLOOD LEVELS IN MG/100 ML			
						before	after	1 day later	3 days later
3	aprobarbital	2	10	24	6				
4	amobarbital	6.67	8	24	7	6.8			
8	secobarbital	2–4	1	6	6	4	4.9	3.5	0.7
	pentobarbital	2							
13	amobarbital	2	5	8	7				
19	amobarbital	1.5	8 (?)	11	6				
	secobarbital	1.5							
20	amobarbital	2.5	6	9½	6	4.1	2.1		
	secobarbital	2.5							
23	secobarbital	4.5	16	22¾	17¼	3	1.4	dialyzed on successive days	
					8	1.3	0.6		
					5½	0.8	0.1		
24	secobarbital	?	9 (?)	12¼	6	3.36	2.65		
25	pentobarbital	3.9	10	17	12	3.1	1.53	0.46	

Comment: A series of non-oliguric acute uremia patients have been reported from the Burns Research Unit, Birmingham Accident Hospital, England.[15] No histologic difference was seen between oliguric and non-oliguric patients.

Attention is called to Finland's review article on the use of antibiotics in renal insufficiency.[16] In fact, unintentional streptomycin overdosage in patients with decreased renal function can be considered an indication for hemodialysis.[17]

#21 26, f.

Renal disease of undiagnosed type. During pregnancy 1½ years before, migratory joint pains with some swelling. Two months before dialysis, puffiness of face, ankle edema, hematuria, proteinuria 3+, no BP elevation. Three weeks before dialysis, marked edema. Questionably positive LE test. Steroids tried. Finally dialyzed. Trouble with bleeding afterwards, from cut-downs, tongue, and bladder. Improvement for only a few days. Remained seriously ill but survived another two months. At autopsy, subacute glomerulonephritis with superimposed pyelonephritis and cystitis.

#22 19, m.

Pfc/Army, pinned under overturned bulldozer. Helicopter evacuation from Waipio to Tripler Army Hospital. Crush injuries of left arm and leg, left hemopneumothorax, avulsion of perineum. Colostomy subsequently performed. Somewhat overhydrated initially in attempt to combat hemorrhagic shock. As expected, progressively developed isosthenuria and oliguria. Transferred to The Queen's Hospital for dialysis. Because of the high catabolic rate in the injured tissues, repeated prophylactic dialyses after the method of Teschan[5] were done, starting four days after the accident, trying to prevent full-blown uremic syndrome. Kidneys began to "open up" two weeks after the accident. Had been on corticosteroids since the accident and shock. Developed sepsis and finally succumbed five weeks after the first dialysis. On postmortem examination, renal tubules showed good regeneration.

Case Summaries of Barbiturate Poisonings

#3 29, f.

Two grams of Alurate (aprobarbital, Roche) ingested; had also been drinking. When seen approximately ten hours after drug ingestion, comatose with deep reflexes absent but vital signs stable. By 20 hours, slight fever, tachycardia if turned. Dialyzed at 24 hours. Some response to cut-down; restless at two hours; responded to name by five hours; thereafter, so restless had to be held down.

#4 43, m.

Ingested 6⅔ g of Amytal (amobarbital, Lilly). Seen approximately eight hours after ingestion. Comatose, areflexic, in shock. Qualitative tests on blood and urine negative for barbiturates. Dialyzed at 24 hours. At four or five hours, groaned, moved head; pupillary reflexes more active, knee jerks sometimes and ankle jerks always elicited. Seventh hour, lifted arms and legs. Fourth hour postdialysis, respirations ceased for 30 minutes; placed on Bennett IPPB machine cycling. Shock difficult to manage; unintentional overhydration using Levophed, 4 ampules/1. Expired third day after dialysis, never coming out of coma.

#8 35, f.

Ingested 2 to 4 g of Seconal (secobarbital) and two grams of Nembutal (pentobarbital). Lavaged for two hours starting less than one hour after ingestion. Less than three hours after ingestion, no response to pain. Dialyzed at six hours. Cut-down without anesthesia. No response during dialysis. One day after run, few swallowing movements. Two days after, responded to pain but still unconscious. Three days after, recognized people; responded to questions. Four days after, better. Five days after, ambulated.

Comment: With our later experience, we would have kept the two above cases on dialysis as long as possible, or would have repeated it within a very short time. Tracheotomy should have been performed early.

[15] Sevitt, S.: Distal tubular necrosis with little or no oliguria, J. Clin. Path. 9:12 (Feb.) 1956.

[16] Kunin, C. M., and Finland M.: Restrictions imposed on antibiotic therapy by renal failure, A.M.A. Arch. Int. Med. 104:1030 (Dec.) 1959.

[17] Edwards, K. D. G., and Whyte, H. M.: Streptomycin poisoning in renal failure: an indication for treatment with an artificial kidney, Brit. M. J. 1:752 (Mar. 21) 1959.

#13 45, m.

Took 2 g of amobarbital. Admitted to Kuakini Hospital five hours after ingestion. Respirations via Bennett machine and endotracheal tube. Dialyzed eight hours after ingestion. At five hours, responding to verbal stimulation. At 5½ hours, opened eyes and responded to questions. At 6½ hours, spoke. At end (seven hours), tried to sit up.

#19 42, f.

Took 1.5 g of amobarbital and 1.5 g of secobarbital (as Tuinal, Lilly). Seen about eight hours after ingestion. Was earlier seen drinking (blood alcohol, 1.5 mg/ml). Comatose, BP maintained with neo-synephrine, respirations cycled with Bennett machine, areflexic. Dialyzed three hours after admission. At 1½ hours, deep tendon reflexes returned. At 1¾ hours, cycled Bennett machine on own. At 2¼ hours, swallowing reflex present. At four hours, corneal reflexes returned. After dialysis, required pressors for 36 hours.

#20 29, f.

Took 2.5 g of amobarbital and 2.5 g of secobarbital (as Tuinal). Lavaged at six hours. Ten ml Megimide I.V. at seven hours. Cut-downs at eight hours; slight reaction to pain. Dialyzed at 9½ hours. Pupils varied in size and response throughout. Ankle jerks elicited momentarily at three hours. Slight reaction to pain at six hours. Six hours later, ate lunch.

#23 47, f.

Took 4.5 g of secobarbital. Found 16 hours after ingestion. Lavaged at 18 hours. Dialyzed at 23 hours. Considerable difficulty performing cut-downs because of inaccessible large arm veins; both femoral veins used. Initial run of 16 hours was longest ever done. Dialyzed three times on successive days. Developed renal shutdown because of shock; treated medically though catheters retained. Dialysis prevented on seventh day of shutdown by partial obstruction of return flow catheter. Recovery from renal shutdown further complicated by Aerobacter aerogenes bacteremia with septic course, and Pseudomonas infection of bladder and cut-downs.

#24 72, f.

Took an unknown quantity of secobarbital. Alcoholic. Admitted and lavaged nine hours (?) after ingestion. Areflexic, comatose, no response to pain. Required tracheal intubation to maintain airway. Megimide, 50 mg IV for five doses; responded a little to pain. However, cut-downs done without anesthesia. Dialyzed at 12¼ hours. Gagging slightly at start so intratracheal tube removed. Restless and stirring at 3¼ hours. Opened eyes a bit when called at 4½ hours.

#25 27, m.

Took 3.9 g of pentobarbital. Lavaged about ten hours after ingestion. Dialyzed at 17 hours. Run of 12 hours was second longest done by us. Semicomatose at end of run with responsiveness increased by Megimide. Next day, awake but sleepy. In another day, talking.

Summary

The first 2½ years' experience with the artificial kidney at The Queen's Hospital has been reviewed. The "kidney" has proved to be simple, safe, and effective. Administrative and technical problems are enumerated. The entire series of cases is presented.

Results with "chronic uremics" proved disappointing in general. Significant prolongation of survival was an exceptional occurrence.

Cases of acute renal shutdown suitable for dialysis were quite rare. This is the group for which the "kidney" was primarily conceived, and any successful application would justify the entire project.

The artificial kidney's effectiveness in hastening recovery in barbiturate poisoning has been amply demonstrated.

Other suitable conditions calling for dialysis exist[18] which we have not encountered, but which we are ready to tackle with confidence. We need to develop a cannulation technique which would permit prolonged repeat dialyses.[6]

Acknowledgement

I am grateful to Dr. W. Harold Civin and Dr. Paul Y. Tamura of the Department of Laboratories for their constant encouragement and enthusiastic support. Miss Margaret Tom provided loyal technical assistance.

[18] Tamura, P. Y., and Civin, W. H.: Artificial kidney—"nephromime," HAWAII M. J. 21:125 (Nov.-Dec.) 1961.

The "sashimi scare" may have been traced to a nematode found in garden slugs and African snails and never before implicated in human disease

Parasitic Meningo-Encephalitis in Hawaii*

A New Parasitic Disease of Man

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A CLINICAL case of parasitic meningo-encephalitis has been fortuitously observed. This entity may be identical with "eosinophilic meningitis" in Tahiti reported by Rosen *et al.*[1] The disease is produced by invasion of the central nervous system by migrating larvae of the rat lungworm, Angiostrongylus cantonensis. This migration parallels the development of the parasite in the usual rat host as determined by Mackerras and Sandars.[2] The term "parasitic meningo-encephalitis" was coined by one of us (J.E.A.).

Case Report

This 62-year-old Japanese yardman was seen on May 29, 1961, complaining of tiredness, generalized achy feeling, and hyperesthesia of the ears, back of head and neck, shoulders, and arms.

There were no remarkable physical findings. He had an old right eyeball injury. Survey chest film was negative. Routine blood count showed a 12,600 white count with 14% eosinophils. When symptoms persisted, the blood count was repeated three weeks later and showed 7,500 white cells with 16% eosinophils.

He denied eating poorly cooked pork but sheepishly mentioned eating two raw garden slugs. This action was based on a Japanese language newspaper account of a medical lecturer from Japan who stated that the eating of snails and slugs "is effective against tuberculosis if swallowed alive. As for the slugs, the slimy ones are good and are helpful in improving the voice of ballad chanters."[3] The general theme of the lecture extolled "raw diet for cleansing of blood." The patient was convinced that slugs would be an unexcelled source of nutritious vitamins and minerals. He was not ill at all but he felt that perhaps his voice was somewhat weak by afternoon of a day of hard physical work.

The slugs were obtained at a lower Manoa valley residence where he was working as a yardman. On May 20, 1961, he ate the first slug. He described how he washed it well, split it open with his fingers and removed the viscera, washed it some more, then chewed it well before swallowing it. Two days later, he experienced chills, aches, and fatigue. He still felt sick but ate another slug in similar fashion on May 24. Again, in two days, he experienced exacerbation of the same symptoms and in addition, noted the hyperesthesia.

On June 29, ten Veronicella slugs were collected from the same yard where the patient had obtained the ones he had eaten. Artificial digestion of these slugs en masse yielded several hundred infective rat lungworm (A. cantonensis) larvae. These larvae produced brain infection when fed to laboratory-raised white rats.

Even though the patient showed no clinical signs of meningeal irritation, a lumbar puncture was done on June 30. The cerebrospinal fluid was clear and the pressure normal. White cells numbered 284/mm^3 with 17% neutrophils, 25% eosinophils, and 58% lymphocytes. Protein was 50 mg%. Quantitative RPCF was "anticomplementary."

Stool examination was negative for ova and parasites.

On June 30 the patient was skin tested using as antigen a physiologic saline extract of powdered adult A. cantonensis diluted 1:10,000. A test with Trichinella antigen, Lederle (1:10,000), was also made. Negative reactions were obtained with the rat lungworm control, Trichinella antigen and Trichinella control. A positive reaction was noted to the rat lungworm antigen. The reaction showed the following: at five minutes, two pseudopods; at 15 minutes, maximal reaction with swelling measuring 1.5 cm in diameter and redness 3.5 cm; at one hour, swelling of 1.8 cm was present but redness had disappeared. One of us (S.R.H.) served as control and showed negative reactions to both the rat lungworm antigen and the rat lungworm control.

* This work was supported in part by grant #E-3072 from the National Institutes of Health, U. S. Public Health Service.
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[1] Rosen, L., Laigret, J., and Bories, S.: Observations on an outbreak of eosinophilic meningitis on Tahiti, French Polynesia, Am. J. Hyg. 74:26 (July) 1961.

[2] Mackerras, M. J., and Sandars, D. F.: The life history of the rat lungworm, *Angiostrongylus cantonensis* (Chen) (Nematoda: Metastrongylidae), Austral. J. Zool. 3:1 (Jan.) 1955.

[3] Oura, T.: Raw diet for cleansing of blood, Hawaii Hochi (five serialized newspaper accounts) (May 2-8) 1961 (in Japanese).

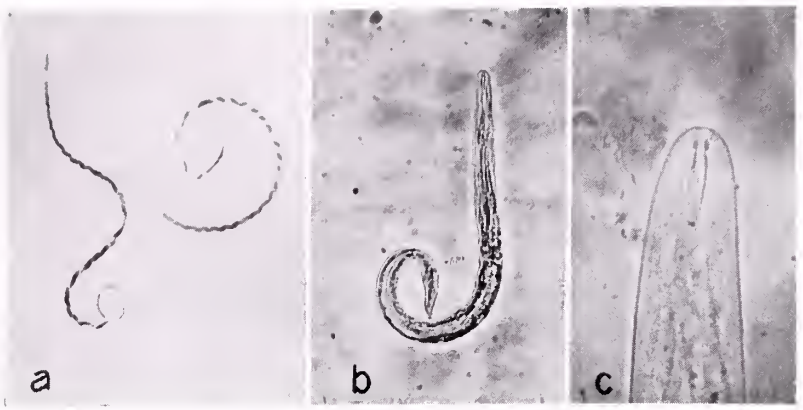


FIG. 1.—*Angiostrongylus cantonensis. (a) Adult females from the lungs of a rat (3×); (b) Infective larva from a land planarian (200×), average size being about 0.42 to 0.49 mm long by 0.025 mm in maximum width; (c) Anterior end of the infective larva with characteristic chitinous rods (stomatorrhabdions) (400×).*

The patient had been treated symptomatically with analgesics. After lumbar puncture and skin tests were done, steroids were started. There was a moderate degree of immediate improvement but mild symptoms did persist.

Discussion

The rat lungworm, A. cantonensis, was first observed in Hawaii late in 1960 by L. R. Ash of the University of Hawaii Parasitology Department, during a survey of parasites of rodents.[4] About 12 per cent of the rats he examined were infected. Suitable carriers of the infective larvae of A. cantonensis in Hawaii include various species of mollusks such as the common garden snail (Eulota similaris), the African snail (Achatina fulica) and the slug (Veronicella leydigi), as well as the land planarian (Geoplana septemlineata).[5]

The possible medical importance of this parasite was recognized by one of us (J. E. A.), who had suggested that it might be involved in the outbreaks of eosinophilic meningitis in Tahiti.[5] A field trip was made to Tahiti in June, 1961, which revealed a high incidence (88.5%) of A. cantonensis among rodents and its presence in various land mollusks and planarians. Experimental infections by the percutaneous and oral routes were successfully achieved in the guinea pig and laboratory rat. A squirrel-monkey was successfully infected by stomach tube by feeding of infective larvae obtained by artificial digestion of mollusks. Developmental larvae were found in the monkey's brain five days after feeding.[5]

A Honolulu pathologist, R. B. Chappell, discovered eosinophilic meningo-encephalitis in autopsies of patients at the State Hospital in December, 1959, and January, 1960. Reexamination of the brain from the second case by Rosen's group at the N.I.H. in April, 1961, disclosed nematodes identified as A. cantonensis.[6]

One of us (J.E.A.) has suggested that human oral and percutaneous routes of infection are possible, viz., accidental ingestion of whole or part of a mollusk or land planarian with improperly cleansed or washed vegetation which is eaten raw, ingestion of larvae with contaminated water, skin infection by handling vegetation containing infected land planarians, or walking barefoot over moist areas in which larvae from crushed or dead planarians or slugs are present.[5] The modes of transmission of the naturally-occurring disease in Tahiti remain to be demonstrated and should be reconciled with the epidemiologic observations of Rosen *et al.* regarding incubation period, age incidence, racial variation, and geographic distribution.[1]

Summary

Report is made of a case of parasitic meningoencephalitis caused by the migration through the brain of developmental larvae of the rat-lungworm, Angiostrongylus cantonensis. This represents the first clinically diagnosed case of a newly recognized illness of man in Hawaii.

Infection of the patient resulted from ingestion of raw slugs (Veronicella leydigi) from an area in Honolulu where other slugs were found in the natural state to harbor infective larvae of A. cantonensis.

The diagnosis was based on neurologic and nonspecific symptoms, presence of eosinophilia in the spinal fluid, and positive skin reaction to A. cantonensis antigen.

It is suggested that this disease may be identical with "eosinophilic meningitis" in Tahiti, reported by Rosen *et al.*

[1] Ash, L. R.: Observations on the helminth parasites of rats in Hawaii and the description of *Capillaria traveri*, J. Parasit. (in press).
[5] Alicata, J. E.: On *Angiostrongylus cantonensis* (Nematoda: Metastrongylidae) as a causative agent of eosinophilic meningo-encephalitis of man in Hawaii and Tahiti. Canad. J. Zool. (in press).
[6] Rosen, L., Chappell, R., Laqueur, G. L., Wallace, G. D., and Weinstein, P. P.: Eosinophilic meningoencephalitis of man caused by a metastrongylid lung-worm of rats, J.A.M.A. (in press).

1010 So. King St.

A rare pediatric abdominal emergency,
successfully managed by surgery and antibiotics

Perforated Duodenal Ulcer in a Premature Infant with Survival

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PEPTIC ULCERATION in children is a well recognized entity,[10] but the rupture of these ulcers in newborns is quite unusual.[11,17,19,27,36] Indeed, the perforation of a duodenal ulcer in a premature infant with survival is very rare.[36] Because of the rarity and seriousness of this lesion, this report is made.

Case Report

A Negro girl weighed 4 pounds, 9½ ounces when born on September 27, 1960, of a toxemic 18-year-old mother whose expected date of confinement was October 11. The mother's blood type was O, Rh positive. Prenatal course was unremarkable until September 26, 1960, when symptoms of severe pre-eclampsia appeared.

At 36 hours of age, the child was given glucose solution orally. Feedings were retained. On the third day of life, when the infant weighed 4 pounds, 3 ounces, she started to regurgitate her formula and some mucus. There were ten such episodes.

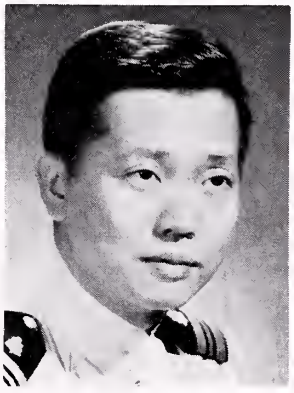
Physical examination revealed a critically ill, moderately dehydrated, and puny infant. Respirations were 44 per minute. The pulse was 164 per minute. The abdomen was markedly distended and tympanitic. Peristalsis was absent.

The hemoglobin was 20.5 grams, the hematocrit was 78%, and the white count was 1,250. Roentgenograms of the chest and abdomen showed a large pneumoperitoneum with diaphragm bilaterally elevated.

On September 30, 1960, under endotracheal anesthesia, an exploratory laparotomy was performed through a right paramedian incision. Generalized peritonitis was found, along with a considerable quantity of serous fluid and milk curds in the abdominal cavity. A four mm perforation in the anterior wall of the first portion of the duodenum was located and repaired with five interrupted sutures of #4-0 black silk. The other viscera appeared normal. A Penrose drain was placed in the right upper abdominal area.

Postoperatively, the child was treated with 4,500 units of procaine penicillin and 40 mg of streptomycin every 12 hours. Balanced electrolyte solution (Ionosol) was given intravenously and a gastric tube was connected to suction.

Leucocyte counts were 17,800 on the sixth postoperative day, 48,600 on the seventh postoperative day, and 31,000 on the ninth postoperative day. However, the white count dropped to 12,440 on the fourteenth postoperative day. Repeated daily examinations and subsequent chest and abdominal roentgenograms were normal.


DR. CHANG

The Penrose drain was removed on the fifth postoperative day. The infant was started at that time on oral feedings. Antibiotics were stopped on the fourteenth postoperative day. On October 30, 1960, the child weighed 5 lbs 2 oz. She was discharged that day to be followed in the outpatient clinic, and has done well subsequently.

Discussion

The first recorded case of perforation of an ulcer in infancy was reported by Siebold[32] in a two-year-old infant. The lesion was found in the stomach. Since then there have been several other cases reported in children.[2,4,8,9,18,21,25,31]

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FIG. 1.—*X-ray showing extensive pneumoperitoneum. Note air-fluid level in abdominal cavity.*



FIG. 2.—*Upright film showing extensive pneumoperitoneum. Air-fluid level is also evident.*

In 1941, Bird[4] collected five cases of rupture of peptic ulcers in newborns (0-14 days), with four deaths. Newman[24] has stated that perforation in children is extremely uncommon. Thelander and Mathes[35] mention that perforation of the gastrointestinal tract before or shortly after birth is rare and associated with a uniformly bad prognosis.

Two of the youngest and smallest children with duodenal ulcer perforation who survived following surgery were those reported by Whittico[36] and Lyday, *et al*[17]. Whittico's[36] patient was a 3 lb 2 oz premature boy, born of an eclamptic mother. Two days after birth, distension of the abdomen was noted. At operation, perforation of the anterior surface of the first portion of the duodenum was found. Lyday, Markarian, and Rhoads[17] sutured a four mm perforation in the anterior wall of the first portion of the duodenum in a 4 lb 10 oz girl. The perforation occurred on the third day of life. There has been a report of perforation of a gastric ulcer in utero.[15]

Incidence

The incidence of perforation of peptic ulcer in infancy is difficult to ascertain, though hemorrhage associated with ulcer appears to be a not infrequent occurrence.[21, 24] Diagnosis of peptic ulceration itself is made only infrequently in children. Alexander[1] pointed out that peptic ulcers often masquerade as chronic appendicitis, allergic indigestion, and neurosis. Therefore, they are frequently overlooked. Benner,[3] in 1943, in 500 routine autopsies, reported an incidence of duodenal ulcer of 1.4%.

Duodenal ulcers have been said to be less common than gastric ulcers in children.[21] However, Bird[4] has shown that the ratio of gastric ulcers to duodenal ulcers is 2 : 1 in early infancy, but after two weeks of age the ratio changes.

The ratio of males to females is about 3 : 2.[21]

Etiology

The probable etiology of peptic ulceration in children has been well covered in excellent reviews[10, 12, 14, 22] and no attempt will be made in this paper to mention any aspect of this phase of the disease.

Pathology

Ulcerations in infants are of the acute type[3, 4, 21] and produce spectacular clinical manifestations, e.g., bleeding or perforation, or both. Therefore, it is possible that a higher percentage of these cases have been reported in the literature than of the chronic type which occurs in older children.[21] Guthrie[10] and Benner[3] emphasized the lack of repair attempts, the absence of inflammatory reaction, and the association rather with necrosis and hemorrhage. Gillespie[9] has mentioned that gastric ulcers occur more commonly on or near the lesser curvature and perforate more frequently than duodenal ulcers. The ulcerations of the duodenum usually occurred in the first portion.[1, 4, 21]

Symptoms and Signs

The symptoms and signs of ulcer perforation in neonates are mainly vomiting, poor feeding, abdominal distention, and irritability.[6,7,27,33] Thelander[34] emphasized the rapid distention of the abdomen as the most consistent finding. Quinn[26] stated that the two diagnostic criteria were pneumoperitoneum and abdominal distention.

Roentgenograms and Treatment

Roentgen examination of the abdomen usually shows much free air within the peritoneal cavity.[21] A large pneumoperitoneum usually points to the stomach or duodenum as the site of disease. Muggia[23] claimed that a perforated duodenal ulcer is the most common cause of pneumoperitoneum in newborns. An upright or lateral decubitus film should demonstrate air in the abdomen.

It has been stated that the great majority of neonates with ulcers either bleed copiously or perforate, or both.[4] Because of the fulminating disease process, very few cases reach the operating room. High mortality is associated with neonatal perforation. Bird[4] has reported a survivor who was a 7 lb 1 oz full-term infant with a ruptured duodenal ulcer which was sutured 34 hours after birth. Whittico[36] and Lyday,[17] respectively, have written of a 3 lb 2 oz premature infant and a 4 lb. 10 oz. girl, who recovered. A case of a three-month-old boy was reported in 1930 by Selinger.[30] Schwartz and Halberstam[28] in 1943 presented the case of an 11-month-old white boy with a perforated duodenal ulcer, with recovery. Rapid diagnosis and early surgery[16] provide the best chance for survival. Since the omentum is so scanty in these infants, walling off of the lesion seldom occurs.

Summary

A case of perforation of duodenal ulcer with resultant generalized peritonitis in a premature infant, successfully treated by emergency surgery, is reported. A review of the American literature is also presented.

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Liver and Biliary Tract Function Testing

With Radioiodinated Rose Bengal

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INTRAVENOUSLY injected radioiodinated rose bengal dye, in conjunction with simple external body counting, provides the following information:

1. Estimation of liver function regardless of the depth of jaundice.
2. Determination of whether biliary tract obstruction is present.
3. Exact localization of the biliary tract obstruction in certain instances.

The body handles rose bengal very much as it does BSP. The radioactive dye has the advantage, however, of being injected in trace amounts and so being usable even when complete biliary tract obstruction is present. It causes no reactions, and since a radioactivity level rather than color provides the end point it can be used regardless of the amount of liver damage or depth of jaundice.

Rose bengal is removed from the blood by the liver cells and is then passed through the cholangioles into the extrahepatic biliary tract. During fasting it collects in the gall bladder (or common duct in the absence of the gall bladder) and is promptly evacuated into the intestine after fat food or cholecystokinin administration. Liver function may be quantitated by obtaining a blood disappearance rate, and biliary tract obstruction may be determined by observing whether dye flows from the biliary tract into the intestine.

Liver Function

Liver function is estimated from the rate of disappearance of rose bengal dye from the blood.[1] A scintillation probe, properly shielded and collimated, is placed against the side of the head of the fasting supine patient (Figure 1). After intravenous injection of tracer rose bengal, count rates are taken over a 20-minute period. The count rate at 20 minutes, compared to 5 minutes, is 50 per cent or less in normal subjects (Figure 2). Profound liver injury causes retention of between 90 and 100 per cent of the dye in the blood; such levels almost always indicate primary liver disease. In borderline liver dysfunction without jaundice, the test compares favorably with the BSI test.

Received for publication July 25, 1960.

[1] Nordyke, R. A., and Blahd, W. H.: The blood disappearance of radioactive rose bengal: rapid simple test of liver function, J.A.M.A. 170:1159 (July 4) 1959.

Biliary Obstruction

Biliary tract obstruction is detected by a second probe placed over the abdomen below the liver (Figure 1).[2] After baseline count rates are obtained, milk or cholecystokinin is administered. If dye then flows into the intestine (indicated by increasing radioactivity beneath this probe) no effective biliary tract obstruction is present (Figure 3). This occurs in most intrahepatic ("medical") diseases with jaundice. It can occur in the presence of nonobstructing common bile duct stones with subsiding jaundice, but will not occur with carcinomatous or other effective obstruction of the common duct.



DR. NORDYKE

Conversely, if dye fails to enter the intestine, biliary tract obstruction is present. This will occur whether the obstruction is intra- or extrahepatic. It occurs in all instances of jaundice due to effective extrahepatic biliary tract obstruction, and in a few instances of the early phase of viral hepatitis, cholangiolitic hepatitis and biliary cirrhosis. Failure of dye to flow into the intestine thus diagnoses biliary tract obstruction but does not localize it.

Localization of Obstruction

It is sometimes possible to localize a complete biliary tract obstruction to the extrahepatic ("surgical") portion of the tract. One method is to "scan" the gall bladder area. A concentration of activity here indicates that no intrahepatic obstruction is present; subsequent failure of the dye to flow into the intestine after cholecystokinin administration localizes the obstruction to the distal common bile duct.

[2] Garcia, A. M., Ahmad, K., Wegst, A. V., and Beierwaltes, W. H.: I^{131}-rose bengal test of liver function: a clinical evaluation, Gastroenterology 37:725 (Dec.) 1959.
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FIG. 1.—*Placement of scintillation probes.* Left *probe is at lateral head to detect rate of disappearance of rose bengal from blood.* Right *probe is over abdomen below liver to detect rose bengal as it flows into the intestine from the biliary tract.*

A second method makes use of the combination of results from liver function and biliary tract testing. When complete obstruction has been demonstrated and the liver function is good (less than 70% retention) the obstruction is surgical.

Jaundice

The approach to the jaundiced patient is as follows. First, the blood retention of the dye at 20 minutes is determined in the fasting state. If this is over 90%, the lesion is non-surgical.

Cholecystokinin is then administered. Flow of dye into the intestine occurs only when there is no effective biliary tract obstruction. Confidence that the disease is non-surgical is 95%.

When dye fails to flow into the intestine, a biliary tract obstruction is present. Most—but not all—of such patients will have surgical conditions. If there is good liver function (below 70% retention) the lesion is surgical.

When the diagnosis is not clear after the above procedure, a second test is done four to eight days later. Thus, the course of the disease may be determined and the problem solved.

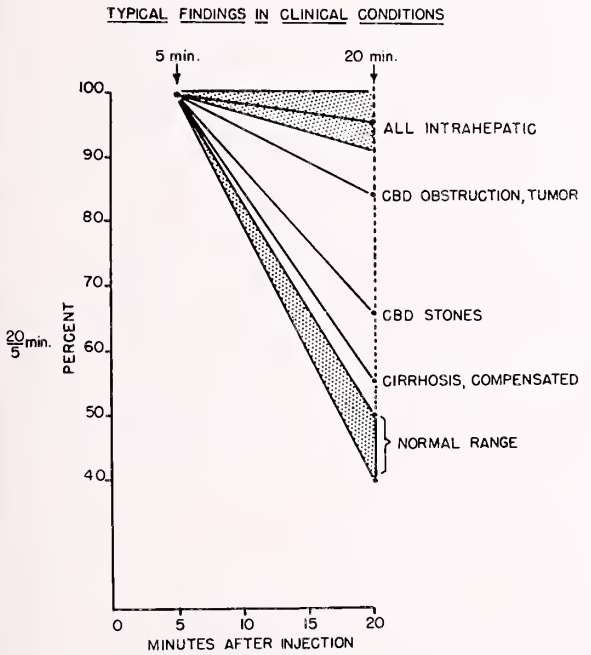


FIG. 2.—*Liver function as determined by the rate of disappearance of rose bengal from the blood (see text).*

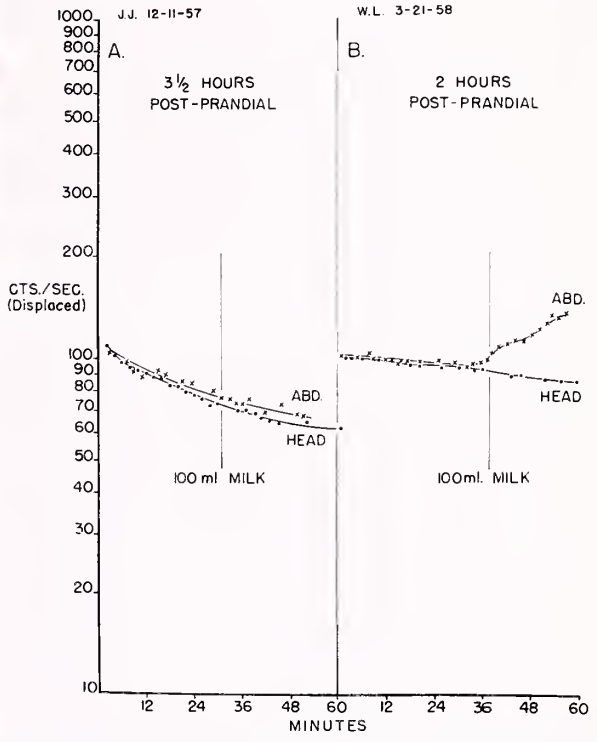


FIG. 3.—*Biliary tract obstruction. A. Complete obstruction by pancreatic carcinoma. No increase in abdominal count rate occurred after milk ingestion. B. Decompensated Laennec's cirrhosis without biliary tract obstruction. The abdominal activity increased after milk ingestion.*

When these procedures were applied to a series of 140 jaundiced patients, a positive diagnosis (intra- vs. extrahepatic) was made in 95. For intrahepatic disease, this was better than any combination of the standard liver function tests done simultaneously; for extrahepatic disease, the tests provided the only positive laboratory criterion for surgical intervention.

It is important to recognize that, although rose bengal testing may be most helpful and often provides the key information needed for proper patient handling, the final interpretation, as with all laboratory procedures, remains in the hands of the clinician.

1000 Ward Avenue.

The President's Page



DR. BURDEN

On my return from a six-week trip on the Mainland I was glad to learn that an excellent contract agreement had been reached between the various county societies and HMSA, giving us the framework for some real advances in providing prepaid medical care of the highest quality for all through HMSA's various plans. Let's get behind this and really make it work. HMSA is better than commercial plans—let's prove it! Only one suggestion for improvement. Let's make the Medical Care Plans Committee, which will negotiate any new plans instituted, a State committee so that all county societies can have their say during the negotiations. This is especially pertinent with the State and County employees plan coming up, a plan which will affect the outer islands proportionately more so than the Federal Plan did.

* * *

While away: Attended a meeting of WICHE and surprised and alarmed to learn that while 25 years ago the majority of medical students came from the A group of students, today only 18% come from the A group and the vast bulk come from the B group. Another indication of the lessened prestige of the medical profession. Several state societies have active programs aimed at interesting more top level students in the study of medicine and allied sciences. The need for establishment of two-year medical schools, in states not having need or capacity for four-year schools, as feeders to the four-year schools, was dramatically presented. This would, in many instances, help persuade more of the top students to think of medicine as a career.

* * *

Am wondering how many doctors have joined a precinct club in their area? The need for all doctors to join a precinct club of their choice, and through it to fight not just socialized medicine but all socializing trends of the Government, is urgent. Shortly after Khrushchev came into power he said, "We cannot expect the Americans to jump from Capitalism to Communism, but we can assist their elected leaders in giving Americans small doses of Socialism, until they suddenly awake to find they have Communism." We see increasing evidence that this is happening and unless we exert our right as free men to join the party of our choice and through it to actively fight the inroads of Government into our God-given freedoms and rights, we will awake someday soon to find that we are in the grip of a completely planned economy, the welfare state under which the Government controls and runs everything, where the Government is supreme and the individual is not free—the kind of system found in Russia today. Every day we see and hear of people and groups calling on the Government to do more and more of those things which we as Americans can and should do for ourselves. Isn't it about time that we take a serious look at this situation and do something about it? And by we, I mean you and I—not someone else. We can do something about it by joining the Hawaii Physicians League for Good Government and by joining your local precinct club and being active in both.

Mahalo!



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[EDITORIALS]

No Hurry About Oral Polio Vaccine

There are two kinds of polio vaccine: killed (Salk) and live attenuated (Sabin). Salk vaccine was supposed to prevent paralytic polio without preventing subclinical polio—but it seems to have done both. Sabin vaccine is supposed to prevent polio, and it seems clear from mass trials in Europe that it does this.

But should we in the U. S. A.—as the A.M.A. recommended last June—start administering Sabin vaccine as soon as we can get it? "No!" says David Bodian of Johns Hopkins.[1] We should not.

In the first place, there is growing evidence to suggest that Salk vaccine may have been largely instrumental in virtually eliminating type II poliovirus from the epidemiologic scene, and in sharply depressing the incidence of cases due to type I virus. Total cases of paralytic polio in the U. S. have dropped from 4,055 in 1959 to 1,573 in 1960 and to 589 so far in 1961—with the summer peak, almost nonexistent this year, well behind us. Hawaii has had 4 cases so far this year.

Would live virus (Sabin) vaccine have done better than this—or could it do better? Perhaps; but there is no evidence that this is so.

If live virus vaccine were given now, on a casual, take-it-or-leave-it basis, would it improve matters appreciably? Not much, surely; it would be almost certain to miss the irresponsible or prejudiced ones who didn't avail themselves of Salk vaccine.

If live virus vaccine were given now on a mass inoculation basis, could we reach the 75 per cent of the total population that would be required in order to accidentally colonize most or all of the reluctant ones? Probably not. The same people who wouldn't take Salk vaccine would probably refuse to take Sabin vaccine, and to these would be added many who, having taken Salk vaccine, would feel they had done all they need to.

Since type I virus is the most important one, would it help matters to go ahead and administer this vaccine to those who would take it? Well, it would do no great harm, as long as we were not planning to follow it soon with types II (licensed for commercial production on October 10) and III (not yet licensed). Only a community *fully* protected by type I vaccine can safely be inoculated with types II or III, since accidental "overflow" inoculation with these latter types would interfere with development of immunity to type I.

Any extensive administration of type I Sabin vaccine, however, would interfere seriously with further evaluation of the effectiveness of the Salk vaccine program—which has itself already been so extensive as to virtually preclude evaluation of any new, superimposed program of oral polio vaccination. A further decrease in the incidence of polio after general administration of type I oral attenuated vaccine would prove nothing—it might be merely a continuation of the effect of Salk vaccine. A spontaneous rise in the incidence of polio under such circumstances would, Bodian points out, be indistinguishable from the result of reversion of the virus to a virulent form, however unlikely this might seem. We might lose; we couldn't be sure we had won.

If the oral vaccine has any present usefulness in our highly Salk-immunized community—and it can't have much—it must be limited to its value in (1) controlling type specific epidemics, if any; (2) immunizing infants; and (3) immunizing any population groups in which few individuals have had Salk vaccine. To attempt more than this, in the light of present knowledge, could do little or no good, and might do irreparable harm.

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Medication By Government Fiat

The pharmaceutical industry is justifiably concerned—and physicians and the public should be, too—about proposed Federal legislation in the drug field. A few outstanding imbecilities that are still in danger of being enacted into law are the following:

1. To require pharmaceutical advertisements to include a list of side effects and contraindications of each drug advertised—which would require so much space that no firm could afford it.
2. To permit patenting of a new drug or drug combination only if the Secretary of Health, Education and Welfare found it had significantly greater therapeutic effect than its predecessors—whatever exactly this might mean.
3. To limit patent rights over new drugs to three years instead of 17—which would hamstring research programs and virtually stop the development of new drugs.
4. To authorize the Food and Drug Administration to make determinations of the efficacy (as well as the safety, strength, and quality) of new drugs.
5. To empower the Secretary of Health, Education and Welfare to determine the official or generic names of new drugs.

The American pharmaceutical industry—John Lear of *Saturday Review* and Arthur Kallet of *Medical Letter* to the contrary notwithstanding—has served this country and the world very well, and still is. And the present powers of the FDA are quite adequate. And free enterprise is still preferable to medication according to the wisdom of Mr. Ribicoff or any of his probable successors.

1984 is approaching fast enough; let's not hurry it!

No More Scruples*

We went behind the screen in a pharmacy the other day. The apothecary handed us a little weight with a stylized "3" on it. "Recognize this?" We confessed that we didn't, though the symbol looked vaguely familiar.

"Ah," he said, "this is a scruple. Perhaps this is the last scruple in town. No one ever prescribes medication in scruple doses any more. No one ever asks me to compound a prescription by taking a scruple or two of some precious drug."

A memory slowly returned. "Twenty grains equal one scruple. Three scruples equal one drachm. Eight drachms equal one ounce."

The word itself stems from the Latin *scrupulus,* meaning "small stone," reminiscent of an earlier "scrupa" for stone. Indeed "scrotum" comes from the same word—stone. A small painted stone was used to chip other stones, as diamonds are used to cut diamonds. So *scrupulus* became the stony little shredder. In fact the word "shred" ultimately comes from *scrupulus*—as, indeed, do "shroud," "screed," and "scrutiny." The little pointed stone became the prick of conscience (scruple in the modern sense). To the Romans it was a way of expressing the smallest weight they could use—the little piece of stone—*scrupulus.* Precious stones were weighed in units of 24—each being a carat. So other items were weighed in units of 24 (a 24th of an ounce), each unit being then a scruple. The scruple then was standardized as the 24th of an ounce—and when the drachm was developed as an eighth of an ounce, a drachm was equated to three scruples. Not until centuries later, could people handle a smaller unit—the grain.

In other parts of the Roman world, the scruple was a unit of currency (their smallest coin) and a unit of longitude (a sixteenth of a degree) and, in some places, even a unit of time.

With the dawn of the Middle Ages, man began to wrestle with his conscience. Sometimes he would be hesitant in his anxiety to determine what was right and what was wrong. The smallest matter might provoke a doubt. A less compulsive man might laugh and say that this was too trifling a matter to hesitate over. But the more conscientious person would not risk his ticket to eternal life by falling down on even the most trivial matter. Hence, the word "scruple"—symbol of the smallest weight—became the word to describe the trifle that caused the troubled man to hesitate. The word was also used in another sense. The ancients balanced their crude scales on a small sharp-pointed stone which served as a pivot. So this small stone (scrupulus) became a term for the axis on which delicate matters could be balanced.

Here then is the rich and romantic history of an ancient apothecary's weight. They complain today that the pharmacist is a repackager of wholesale drugs. But a generation or two ago he was the heir of the alchemist; he was the artist who compounded the prescription. He did it with care, measuring every scruple, every drachm, every grain. He was precise. In both senses of the word, he had scruples.

Today's medical student knows neither the word nor the symbol. Well, we no longer need that weight. With our sterile, colorless, but efficient metric system, we can forget the drachms, and grains—aye—the scruples too—that once lent color and variety and preciseness to the ancient art of the apothecary. We can scuttle the scruple. And too often we do just that.

* Editorial from *The Journal of the Medical Society of New Jersey,* 57:2 (Jan.) 1960.

This is What's New!

Radiologists in Philadelphia advocate **periodic x-ray examination of breasts** as a **screen for malignancy.** Periodic x-ray examinations were performed at six-month intervals for five years on 1,300 women with the discovery of 23 carcinomas of the breast. In six patients the tumor was not palpable and operation was performed because of x-ray findings alone. (*J.A.M.A.* [July 1] 1961.)

* * *

"All persons are cautioned to avoid handling abnormally behaving bats and, if bitten, are advised to try to catch the bat and immediately notify a physician." This advice was given to the residents of New York after two children were bitten by **rabid bats** in unstate New York. Fortunately, there is no rabies in Hawaii, due to the strict animal quarantine. Bats, perhaps the rarest species in the world, do exist in the upland areas of Hawaii but have rarely been seen even by kamaainas. (*Modern Drugs* [Sept.] 1961.)

* * *

Dragstedt asks Dragstedt: "Why does not the **stomach** digest itself?" and then proceeds to answer this by explaining the duodenal and antral **inhibitory mechanisms** that check the secretion of gastric juice." (*J.A.M.A.* [Sept. 16] 1961.)

* * *

The widely used diuretic antihypertensive, **chlorothiazide, causes pancreatitis** in mice and, if elevated serum amylase is indicative of pancreatitis, also causes it in 50 per cent of humans treated with this drug. (*New Eng. J. Med.* [Oct. 5] 1961.)

* * *

The Hilo **tidal wave** of 1960 killed 61 people in spite of a 20 minute warning siren that was sounded four hours before the wave hit. Even the 300-odd people who successfully evacuated before the wave admitted to a **confused and apathetic response** to the **warning signals.** This response to warning signals should be carefully studied by those who must deal with natural or unnatural disasters. (*Science* 133:1405, 1961.)

Spironolactone, in contrast to hydrochlorothiazide, does not cause hypotension or oligemia in nonedematous, hypertensive patients. However, the combination of **spironolactone** and **hydrochlorothiazide** enhances the hypotensive effect of hydrochlorothiazide but **hypokalemia is prevented.** (*Arch. Int. Med.* [Sept.] 1961.)

* * *

Gallstones and diabetes are a frightful combination. Diabetics requiring emergency surgery for their gallstones have a mortality five times as great as that of nondiabetics. In the 51 to 65 age range, the mortality among diabetic patients requiring gall bladder surgery was 20 times greater than among nondiabetics. The authors advise **cholecystotomy more frequently** for **acute cholecystits,** and **prophylactic cholecystectomy** in **diabetics with gallstones.** (*Am. J. Surg.* [Aug.] 1961.)

* * *

The **routine use of quinidine** (0.3 grams q.i.d.) immediately after **myocardial infarction** did not reduce the death rate nor did it reduce the incidence of cardiac arrhythmias in a small group of patients so treated. (*Brit. Heart J.* [July] 1961.)

* * *

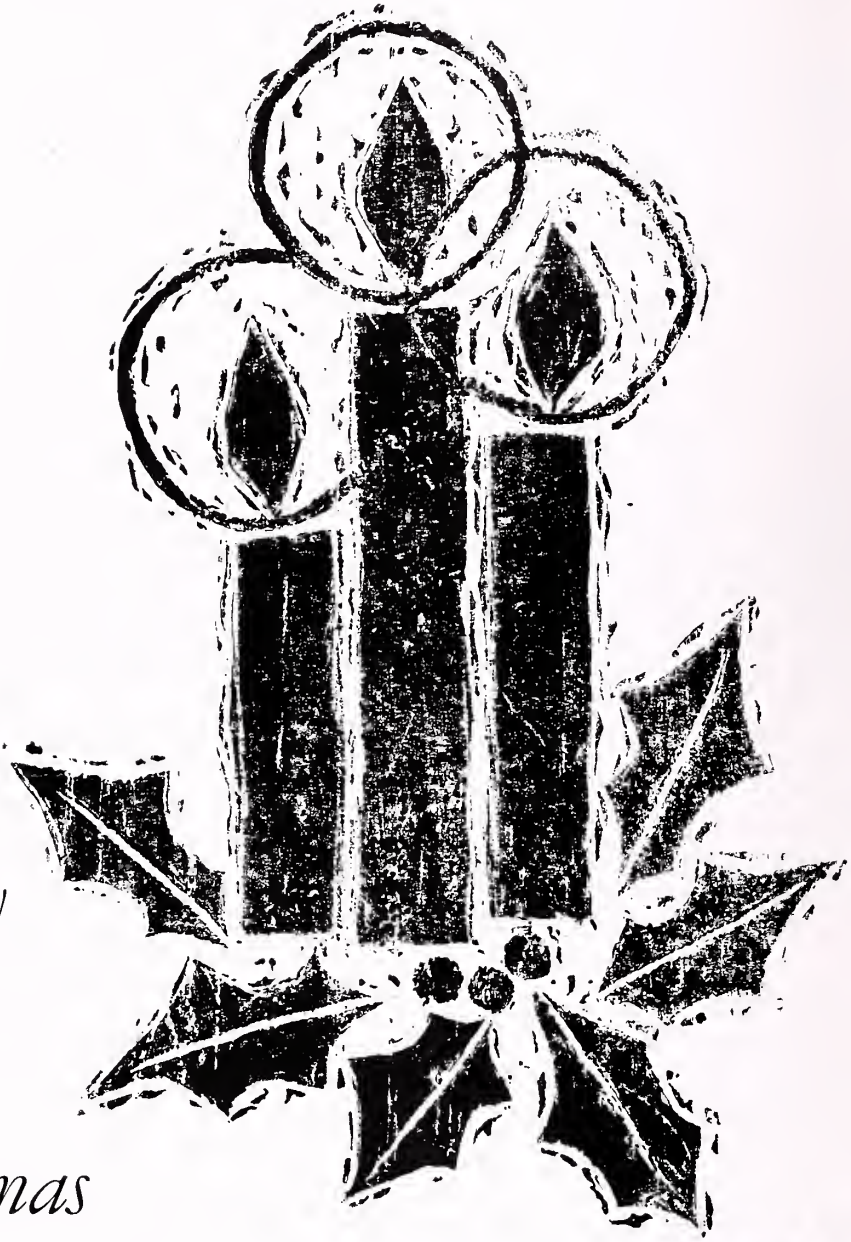
It takes a lot of **penicillin** to **prevent rheumatic fever** in children. Of 2,500 children seen because of sore throat, half had beta hemolytic streptococci. Of the group harboring the beta strep, half received 600,000 units of Benzathine penicillin while the other half (600) received symptomatic medication. Two of the 600 controls developed rheumatic fever while one developed acute nephritis. No such complications occurred in the 600 patients treated with penicillin. (*J. Med.* [Sept. 21] 1961.)

* * *

Bizarre premature ventricular beats were always associated with heart disease in 4,000 hospitalized patients. The more "normal" premature ventricular beat was found in the electrocardiogram of both healthy and diseased hearts. (*Am. J. Med Sci.* [Sept.] 1961.)

FRED I. GILBERT, JR., M.D.

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In Memoriam - Doctors of Hawaii - XXXV

This is the thirty-fifth installment of the Memoriam—Doctors of Hawaii.

Irwin James Shepherd

Irwin James Shepherd was born in Lebanon, Kent County, Delaware, on February 23, 1874. He was the son of James Henry and Mary Jane (Jester) Shepherd.

After the death of his father and the remarriage of his mother, he lived in Delaware City, Delaware, with an uncle who was a druggist. Young Shepherd became a licensed pharmacist before he entered medical school.



DR. SHEPHERD

He attended the public schools of Delaware, graduated from Delaware College in 1894, and received his M.D. degree from the University of Pennsylvania in 1899. He interned at the U. S. Marine Hospital Station, Stapleton, Staten Island, New York, from 1899 to 1900.

Dr. Shepherd was physician for the LaFollette Coal, Iron and Railway Company in LaFollette, Tennessee, from 1900 to 1905. During the same period, he was also local surgeon for the Southern Railway Co.

On June 3, 1903, he married Logan Locker Warner at LaFollette, Tennessee. The couple had three daughters: Logan Mary (Mrs. Herbert M. Richards, deceased), Carolyn Warner (Mrs. Harold S. Burr), and Elizabeth Morrison (Mrs. James M. Murray).

From 1905 to 1910, Dr. Shepherd practiced in Wilmington, Delaware. He was on the medical and surgical staff of Delaware Hospital, visiting physician of Children's Hospital in Wilmington, Delaware, and also visiting physician from 1907 to 1910 of the Open Air Tuberculosis Hospital. He was medical referee for the Mutual Life Insurance Company of New York, 1907 to 1937.

Dr. Shepherd arrived in Honolulu October 4, 1910. He engaged in private practice, being associated with Dr. William C. Hobdy from 1910 to 1920, when Dr. Hobdy left the Territory. Within two months after his arrival in Hawaii, he was on Maui directing and setting up treatment centers for the epidemics of smallpox and scarlet fever which broke out in December of that year. Dr. Shepherd was General Health and Sanitary Officer for the Territorial Board of Health, Bacteriologist, Pathologist, Medical, and Sanitary Officer for the Territory in 1911. During 1911 and 1912 he was acting Assistant Surgeon, U. S. Public Health and Marine Hospital Service.

He was president of the Medical Society of Hawaii in 1917. He was on the staff at The Queen's Hospital until his death and practiced also at St. Francis Hospital, Kauikeolani Children's Hospital, and at Kapiolani Maternity and Gynecological Hospital.

During World War I Dr. Shepherd was a Captain in the Medical Corps, U.S.A., from October 9, 1918, to July 31, 1919, and was stationed first at Schofield Barracks and later at Fort Shafter. While on duty at Schofield Barracks, General Hurd had Captain Shepherd lay out the original nine-hole golf course for the Post.

He was a member of the Medical Club of Philadelphia, American Medical Association, Medical Society of Hawaii, University Club of Honolulu, the Pacific Club, Oahu Country Club, American Legion, University of Pennsylvania General Alumni Association, and University of Pennsylvania Club in Hawaii. He served as the first president of the University of Pennsylvania Club in Hawaii in 1936, appointed as a member of the University of Pennsylvania Bicentennial Committee of the Hawaiian Islands in 1937. Dr. Shepherd was also licensed to practice in California.

Dr. Shepherd died in Honolulu on October 21, 1937, at the age of 63.

MRS. IRWIN J. SHEPHERD

Martin Hagan

Dr. Martin Hagan was a graduate of Starling Medical College, Columbus, Ohio, in 1859 and also studied at the College of Physicians and Surgeons in New York.

After serving with the Union forces in the Civil War, he practiced in St. Paul, Minnesota, until 1881. In that year he came to the Island of Hawaii where he was associated with Dr. Lyman S. Thompson of Kohala, and later took over Dr. Thompson's practice while he made a trip to the mainland. A newsletter from Kohala written in February, 1882, says, "we note upon the return of our M.D. (Thompson) from the Coast both he and his popular partner (Hagan) ignored saddle horses and now drive around in a stylish vehicle. We like to see such advances."

By June, 1882, Dr. and Mrs. Hagan had moved to Honolulu where the doctor had his residence and office at 123 Fort Street. One of his cases was considered unusual enough to be described in the *Advertiser* of July 1, 1882, as follows: "A cure of an aggravated case of harelip on a 8-year-old boy was accomplished by Dr. Hagan. By paring the lip and making an incision on the inner side of it and then sewing it together with silver thread, Dr. Hagan . . . made a most successful restoration of the lad's lip."

That same year Dr. Hagan was appointed physician for the Insane Asylum and expended a great deal of time and care in planning a $6,000 addition to the institution. Early in 1883 when the new addition was opened an editorial in the *Advertiser* reported, "The arrangement of this room (a sitting room for the patients) particularly illustrates the happy taste and wise judgment of Dr. Hagan, who has indeed planned the whole structure."

The doctor was one of the prime movers in the organization of the George W. DeLong Post of the G.A.R. and was elected the first post surgeon in December, 1882. He was also a member of the Knights of Pythias. The Hagans took an active part in the social life of the day and were among the guests invited to the Coronation Ball of King Kalakaua, on February 20, 1883.

On July 15, 1884, Dr. and Mrs. Hagan left on the "Mariposa" for San Francisco. It was announced that he was going for a few months' visit and to improve his health, but where he became City Physician in 1887 and is credited wit hefficiently handling the smallpox epidemic of 1887-1888.

Dr. Hagan died in Los Angeles January 23, 1901, at the age of 68.

County Society Reports

Hawaii

The August 16, 1961, meeting of the Hawaii County Medical Society was held at the Hilo Hotel. Guests present were Dr. J. A. Rider, Asst. Clinical Professor of Gastroenterology at the University of California Medical Center; Dr. S. Kurohara, Dr. Best, and Dr. Bracher.

Dr. Haraguchi announced the resignation of Dr. W. N. Bergin as Councilor. Dr. Robert Miyamoto was recommended by Dr. Haraguchi to take the place vacated by Dr. Bergin.

President Haraguchi next read HMSA's letter to the Society informing the membership that a Kaiser Hospital may be built here in Hilo.

A letter from the ILWU was read by Dr. Haraguchi informing the membership that members visiting neighbor islands will be covered for emergency care under the "Plantation Plan."

Dr. Wipperman moved, seconded by Dr. M. L. Chang, that the Secretary inform Kona Inn that the County Medical Society does not endorse the letter written by Dr. J. E. Mitchell to Kona Inn recently in regard to the emergency care of visitors at the Kona Inn. The motion was carried unanimously.

Following the business portion of the meeting, Dr. J. Alfred Rider gave an interesting talk on the "Hypersensitivity Factors in Ulcerative Colitis."

* * *

The September 21, 1961 meeting of the Hawaii County Medical Society was held at the Naniloa Hotel. Guests present were Drs. Miller, Walsh, Bracher, and Best.

A short discussion was held in regard to the signing of individual contracts and society contract with HMSA. Several points were discussed by Dr. Lewis. A motion by Dr. Yuen, seconded by Dr. Lewis, that the Society accept the contract with HMSA was carried unanimously.

Dr. S. Haraguchi then read a letter from Dr. James Luce, an associate member of the Society, requesting clarification of his status since he has discontinued his residency training and is now working in Asia under Medico. Dr. Eklund moved, Dr. Oda seconded, that Dr. Luce should be kept on the associate membership during the duration of his duty in Asia under Medico. The motion was carried unanimously.

Following the business meeting Dr. E. W. Best gave an interesting and informative talk on "Determination of Enzymes in the Clinical Laboratory."

FRANCIS F. C. WONG, M.D.
Secretary

Honolulu

The meeting was called to order by President Hartwell at 7:40 p.m., July 11, 1961. Approximately 112 members were present.

Dr. Charles T. H. Ching and Dr. Mor J. McCarthy, new active members, were welcomed into the Society by Dr. Hartwell.

Dr. Verne C. Waite, elected representative of the HCMS Delegates, reported to the membership the proceedings of the last House of Delegates meeting. Dr. Waite presented the highlights and some of the actions taken by the delegates which he felt should be brought to the attention of the membership.

It was suggested by the Chair that for the purpose of facilitating the approval of the Bylaws, this meeting be turned into a Committee of the Whole and that Dr. Ando be appointed as chairman. It was moved, seconded and passed that Dr. Hartwell's suggestion be approved.

Dr. Ando assumed the chair and discussed briefly the Bylaws Committee's objectives and the major changes made in the Bylaws.

A full discussion was held on the amendments made to Chapters I through VIII, and the following actions were taken:

> *Chapter IV, Section 3:* It was moved, seconded and passed that discussion of this section be postponed until our relationship with HMSA is clarified.
> *Chapter V, Section 3(c), Line 39:* The word "Hawaii" in Hawaii General Surgical Society was amended to read "Honolulu" General Surgical Society.
> *Chapter V, Section 3(j), Lines 44 and 45* was amended to read "The president or the presiding officer, at his discretion, may designate a member of this Committee as a . . ."

Chairman Ando then entertained a motion "That the Committee of the Whole rise and recommend that the Bylaws be adopted as amended on the floor." It was moved, seconded and passed that the Committee of the Whole rise and report its deliberations to the membership. They were so reported by the chairman. The Committee of the Whole was then dissolved.

Dr. Hartwell stated that he would entertain a motion to adopt the Bylaws in toto. It was moved, seconded and passed that the Bylaws as amended be approved. The Chair then stated that these Bylaws are now adopted.

A resolution in memory of Dr. Kenneth On Ching was read by Dr. Randal Nishijima.

Dr. Nishijima moved the adoption of the resolution and requested that the membership stand for a minute of silence in memory of Dr. Ching. The motion was seconded and passed.

The chair presented, for those who were not familiar with the details, a recapitulation of the history of the County Society's relationship with HMSA and the events leading up to the termination of the master contract by HMSA. He then read excerpts from a letter from HMSA dated May 26 pertaining to several arrangements HMSA hopes to effect in future relationship with the Society; a letter to Mr. Oliphant, President of HMSA, from the Society dated July 7 requesting that provisions of the contract be extended for 60 days; and a reply from Mr. Oliphant dated July 11 stating that it would be impracticable to try to restore the former arrangements and that as much time and effort would be expended to accomplish that as would be required to work out a mutually satisfactory new relationship. He went on to state that efforts to solve the problem have been made by our Executive Secretary who has met with Mr. Veltmann and Mr. Yuen of HMSA on this matter and also Dr. Burden, President of the HMA, who has met with HMSA and who feels that a master contract with the State Association would solve the problem.

The Chair then opened the meeting to the membership for discussion but first asked the members to keep in mind several things: (1) That the situation between

(Continued on page 166)

Book Reviews

★Hospitals, Doctors, and Dollars

By Robert M. Cunningham, Jr., 268 pp., $6.95, F. W. Dodge Corporation, 1961.

Almost anyone will concede that the three subjects mentioned in the title of this book have enjoyed increasingly bad public relations in the past decade. Reading this book is no task. It is entertaining and delightful and excellent to read just for fun, and a perusal of it will give the reader an idea of why this depreciation in the public's eye of the virtues of Hospitals, Doctors, and Dollars has come about. Incidentally, many suggestions are made for improving this situation, although the difficulties of accomplishing this are great.

The book is a must for every hospital administrator, every hospital trustee, and every physician who has any interest in the public image of his profession.

H. L. Arnold, Sr., M.D.

Resuscitation of the Newborn Infant

Edited by Harold Abramson, M.D., 274 pp., $10.00, The C. V. Mosby Co., 1960.

This is a book that should be readily available in our delivery suites and in our newborn nurseries. It is primarily designed for obstetricians and delivery- and nursery-room personnel. After a difficult resuscitation of a newborn infant, the harried accoucheur could do no better than to read or reread the chapter entitled "Resuscitation Procedures in the Delivery Room." Evaluation and treatment of the newborn in the nursery is adequately handled; and the author's plea for a recovery room nursery for high risk infants is well taken. Those chapters dealing with physiology, biochemistry, pathology, and obstetrics shed little new light on the perplexing problem of the depressed newborn.

David A. Sinclair, M.D.

★Practical Diagnosis and Treatment of Liver Disease

By Carroll Morton Leevy, M.D., 336 pp., $8.50, Hoeber-Harper, 1957.

This neatly organized book of some 300 pages covers almost all of the knowledge of liver disease that might be useful to a clinician. There is good correlation between clinical observations and laboratory findings. The charts and diagrams are clearly presented and there are a number of colored photomicrographs illustrating the varied types of pathology. Clinical features of the various types of liver disease are frequently nicely brought out in the form of a case history, with a more detailed discussion following. Therapy is discussed in general principles but with enough detail to be of considerable value to the practitioner. In the discussion of therapy, there is a healthy avoidance of the usual long lists of remedies that have been advised at one time or another. A recommended addition to the library of a physician who would diagnose or treat liver disease.

Fred I. Gilbert, Jr., M.D.

★ Highly recommended.

Proceedings: Thirteenth International Congress on Occupational Health

By The U.S. Executive Committee of the Thirteenth International Congress on Occupational Health, 1005 pp., 1960.

This collection of papers on occupational health runs to 1,005 pages, plus a table of contents of 30 pages. The papers run the gamut from "Health and Safety Considerations at the Nuclear Power Stations of the Central Electricity Generating Board," through "Ist Epicondylitis Eine Berufskrankheit?" and "Les Critères Medico-Psychologiques de L'Aptitude des Travailleurs au Sahara" to "Wound Infection and Its Prevention in Industry." This volume could be a valuable reference work for the industrial physician were it not for the fact that there is no alphabetical index.

Frank H. Hatlelid, M.D.

★Biochemistry of Blood in Health and Disease

By I. Newton Kugelmass, M.D., Ph.D., Sc.D., 543 pp., $15.75, Charles C. Thomas, 1959.

All of us are aware of the rapid expansion of knowledge in the field of biochemistry as it affects medical practice. It is seldom, however, that we have the opportunity to gauge its almost explosive force. The appearance of this really superb text brings it home to us, however, since some of its sections were quite obsolete when the first copies rolled off the press. For example, the chapter on hemoglobinopathies does not include any references later than 1958, so that the new standardized system of nomenclature is not included, many new hemoglobinopathies are omitted, and discussion of the variations in the amino acid structure of abnormal forms is too superficial. In spite of this the chapter is a good one and merits careful study, since it gives a lucid summary of the work done in this field up to the time of preparation of the text. The separate subjects are illustrated with a host of lucid charts and diagrams. They explore almost every facet of the function of the blood as a living, dynamic substance. It deals not only with the adult, but the neonatal infant and child as well. Each paragraph is solid fare unrelieved by literary frills. Hence it is useful primarily as a reference work. It is heartily recommended.

Grant N. Stemmermann, M.D.

★Visual Aids in Cardiologic Diagnosis and Treatment

Edited by Arthur M. Master, M.D., and Ephraim Donoso, M.D., 216 pp., $10.00, Grune & Stratton, Inc., 1960.

It was with a great deal of interest that I read this volume describing some of the newer visual aids in cardiological diagnosis and treatment. The first chapter was indeed intriguing, describing the machine and physician in the present and future of heart disease. From there the book went into the pathological anatomy of surgically correctible congenital malformations. Auscultation

(Continued on page 174)

Notes and News

Names in the News

Dr. Harry L. Arnold, Jr., was named chairman of the professional division for the Community Chest campaign. He was also prominently headlined on his comments on public apathy when his 15-year-old son was attacked without provocation.

Dr. Sumner Price's report on nursing homes in the city made quite a splash.

Dr. Raymond Hiroshige reported the burglary of office equipment worth $1100. **Dr. R. Mookini,** also victimized, lost a typewriter.

Dr. Nils P. Larsen, commenting on USC's research on female hormones reducing male heart attacks, said "such results are not quite acceptable as yet."

Drs. Richard E. Ando and **Joseph T. Nishimoto** were mentioned as candidates for the State Board of Education.

Awarding a certificate of operation to the new Royal State Insurance Company made possible favorable publicity for **Drs. William Bergin** and **Edmund Lee.**

Dr. William Goodhue of Kauai made the news when a stevedore was killed in a fork-lift mishap.

Dr. R. Frederick Shepard received well-deserved plugs from a local columnist and publicity for the Rehabilitation Center was enhanced by the presence of a prominent entertainer as a patient.

Dr. and Mrs. Douglas Bell were kept hopping recently. The cause—two grandchildren visiting from Denver.

Dr. Blaine Boyden, son of **Dr. Webster Boyden,** former HMA president, got "hitched."

Dr. Walter Quisenberry reviewed his pet subject, ethnic relationships of cancer, at a recent Pacific Science Congress.

A fine panel consisting of **Drs. Waite, Judd, Richard Chang,** and **Tamura** did a swell job on KONA-TV on the subject of cancer.

CLARENCE JUNRO KUSUNOKI, M.D.
1910-1961

Clarence Junro Kusunoki was born in Honolulu on July 13, 1910. His parents were Torajiro and Kiku Kusunoki. He attended Royal Grammar School and McKinley High School in Honolulu, and then took his pre-medical course at the University of Hawaii from 1929 to 1933, where he received his B.S. degree.

Dr. Kusunoki graduated from the Washington University Medical School at St. Louis, Missouri, in 1937. He interned at the St. Francis Hospital at Peoria, Illinois, from 1937 to 1938, and The Queen's Hospital in Honolulu from 1938 to 1939. He then did some graduate work in public health at the University of Minnesota from 1939 to 1940, following which he returned to Hawaii and became Health Officer on the Island of Maui for three years. After that, he did general practice in Honolulu until 1945.

In 1945, Dr. Kusunoki went back to his alma mater, Washington University Medical School, and took postgraduate work in otolaryngology for six months and then served as a resident in otolaryngology at the Barnes Hospital at St. Louis, Missouri, until 1948. He then opened his office in Honolulu and continued to practice otolaryngology until his untimely demise.

In 1937 Dr. Kusunoki was married to Meredith Skinner in Peoria, Illinois. He is survived by his wife and two daughters, Ida Pat and Georgiana; a brother, Creighton N. Kusunoki; and two sisters, Alice S. Kusunoki and Mrs. Ethel Smith.

Dr. Kusunoki was stricken suddenly and died in a few hours at the Kuakini Hospital in Honolulu on August 13, 1961. A Requiem Mass was offered on August 19, 1961, at the Star of the Sea Church and the burial was at the Diamond Head Memorial Park in Honolulu.

Dr. Kusunoki was a member of the American Medical Association, the Hawaii Medical Association, the Honolulu County Medical Society, and the American Academy of Ophthalmology and Otolaryngology, and a Fellow of the International College of Surgeons. He was also a diplomate of the American Board of Otolaryngology. He was on the active staff in his specialty at Queen's, St. Francis, Children's, and Kuakini Hospitals in Honolulu.

The people of Hawaii lost a very capable physician in Dr. Kusunoki. To all of his friends his sudden demise was a great shock. He was one of Hawaii's most outstanding otolaryngologists.

To many, many people Dr. Kusunoki was known as an all-around athlete. He was a splendid basketball player in high school and college and an ardent bowler in recent years. He was well liked by his bowling colleagues because of his sportsmanlike and gentlemanly behavior, in addition to his great competitive spirit. In fact he became sick while bowling that fatal Sunday afternoon, when he drove his car to the Kuakini Hospital to be admitted there.

Dr. Kusunoki's passing is most keenly felt by the Kuakini staff and others closely associated with the institution. He had served on the executive committee of the medical staff and other committees, in addition to being chief of the otolaryngology service for many years. He was highly respected by his colleagues and the hospital staff for his professional ability and persistent interest in raising the standards of medical practice. Kuakini Hospital lost a faithful and an influential friend.

We extend our profound sympathy to his wife and daughters. May God bless Dr. Clarence Junro Kusunoki.

THOMAS H. MAEDA, M.D.

The August 31 issue of the evening paper carried a nice story of the agreement reached by the HMSA and the HCMS. Pictured signing the agreement were **Dr. A. S. Hartwell,** HCMS president; executive secretary **Dick Kennedy;** and **Joe Veltmann** and **Ted Oliphant** of the HMSA.

Dr. R. B. Cloward offered a $100 reward for the return of a lost camera.

Special editions commemorating the 50th Anniversary of the Chinese Chamber of Commerce featured many of our colleagues. Prominently featured were **Dr. A. Ng Kamsat,** general chairman of the Chamber's Golden Jubilee events; **Dr. Fred K. Lam,** for his former contributions to the study of the liver fluke; former HCMS presidents **Drs. W. K. Chang** ('32) deceased, **M. F. Chung** ('34), **Fred K. Lam** ('42), **Sam L. Yee** ('50) also HMA president, and **H. Q. Pang** ('60); **Dr. Richard K. C. Lee,** as director of the State Department of Health; also **Drs. Min Hin Li** and **Herbert Chinn** were mentioned. Somewhat embarrassing was **Dr. Robert C. H. Chung,** who was prominently mentioned. The Korean community temporarily lost a good man!!!

Dr. Edward Boone, Chairman of the Emergency Medical Service Committee of the HMA, has been spearheading disaster rehearsals aimed at developing mass medical care programs.

Drs. Duke C. Choy, John C. Milnor, and **George Ewing** spoke at the Mabel Smyth on causes of mental retardation.

The **Pacific Medical Associates–Henry J. Kaiser** feud was settled out of court recently. The amount or how the settlement came about was not disclosed. We are all curious!!!

Dr. Leabert Fernandez was happy and proud to learn that his son, a midshipman at the U. S. Naval Academy, was named to the Superintendent's List.

Dr. William N. Bergin chaired the recent District Information Institute in his capacity as the Rotary District Governor.

EDWARD S. KUSHI, M.D.
1906-1961

For the past 25 years, Dr. Edward S. Kushi has been in general practice. He was respected by his colleagues and loved by his patients. His sudden, untimely passing on September 5, 1961, was a great loss to the community.

He was born in Puunene, Maui, on November 20, 1906, the son of Sukehito and Uto Nakayama Kushi. He graduated from McKinley High School in Honolulu in 1925 and from the University of Hawaii in 1929 with an A.B. degree. He received his M.D. degree in 1932 from the College of Medical Evangelists in Los Angeles. Dr. Kushi interned at Santa Fe General Hospital in Los Angeles and did specialized training in children's diseases for 18 months at Hollywood Children's Hospital. He was a diplomate of the National Board of Medical Examiners.

For a few months in 1936 he practiced in Papaikou, Hawaii, associated with Dr. T. Kutsunai. However, his practice had been principally confined to Wailuku, Maui, since 1936. He was an active member of the Central Maui Memorial Hospital Medical Staff, Maui County Medical Society, Hawaii Medical Association, and the American Medical Association. He was also Assistant Maui County Physician from 1937 to 1943.

Dr. Kushi's life was one replete with numerous accomplishments, varied abilities, and multiple interests. He served on the Maui Police Commission from April 23, 1951, to August 2, 1954. During the trying years of transition from the old Malulani Hospital to the new Central Maui Memorial Hospital and the years that followed, he was a guiding light in effecting an orderly transformation and an eventual efficient, well-equipped, and modern hospital, for he was chairman of the Maui Hospital Managing Committee from July 1, 1949, to April 5, 1954. Those in the administrative, medical, and nursing fields can well understand and appreciate what this entailed. Perhaps this talent for organization and administration evolved from his experience of serving in the Medical Corps of the Hawaii National Guard from June 2, 1947, to June 8, 1951, when he retired medically as a Captain.

Although he was not a participating athlete, he was a lover of all types of sports and contributed much to them. His greatest inclination swerved toward football. He organized and owned the Cardinals football team in 1944. This team was supreme, winning many games in 1944 through 1946, promoting and adding new interest to senior league football. For many years he has volunteered his services to the Baldwin High School football team as its physician, treating injuries at the games and at the same time giving inspiration to the players. Boxing fans and boxers will also miss his charitable actions and services from ringside, for he gave much of his energy and skill as boxing physician. The absence of this familiar figure will be felt at basketball and baseball games, as well as on the golf course.

Being a man of benevolence and generosity, he had played host to many service personnel during World War II years, offering them comfort and entertainment by actually converting his home into a veritable U.S.O. His home was a home away from home for many servicemen. This they will never forget.

Possessor of a rich tenor voice of clear quality, he was always ready for a song as he strummed his own accompaniment on his guitar. His perennial and familiar strains of "Memories" and "Up The Lazy River" will be missed at our annual Hawaii Medical Association meetings.

Truly he was a kindly, friendly, jovial, and versatile man. Those in all walks of life who had the pleasure of his association have known him to be a diligent physician, enthusiastic sportsman, and a loyal friend.

Left to mourn his passing are his two sons, Gerald and Edward, Jr., two brothers, Dr. Harold S. and Sukeyoshi Kushi, and a sister, Mrs. Chiyo Yogi.

A. Y. Wong, M.D.

Dr. I. Katsuki, 96-year-old father of three local physicians, was prominently mentioned in a recent article on the bubonic plague epidemic of 60 years ago.

Keo Nakama's great feat of swimming the Molokai Channel from Molokai to Oahu was helped by **Drs. Coolidge Wakai** and **Nobuyuki Nakasone.**

Dr. William W. L. Dang was named new chairman of the executive committee of the Oahu unit of the American Cancer Society.

Dr. Fred Giles urged epileptics to stay out of the water after a recent incident in the drowning of an epileptic student.

Congratulations

It's twin girls to **Dr. and Mrs. Robert A. Nordyke,** and one girl to **Dr. and Mrs. Donald Smith.** The jackpot to **Dr. Albert Ishii,** a boy after three girls, and a boy to **Dr. and Mrs. Noburo Oishi.**

To Hawaii's pathologists who were hosts to the Pan Pacific Pathology Congress, October 8 to 14. Sessions were held at the Sheraton Meeting House and at Tripler Hospital. Some 135 attended from the mainland U. S., Canada, Australia, New Zealand, Japan, and the Philippines. **Dr. G. N. Stemmermann,** Secretary, Hawaii Society of Pathologists, was in charge of arrangements which received wide acclaim from the visitors. **Dr. I. L. Tilden,** President, said virtually all the delegates attended all the meetings instead of using Waikiki Beach as a laboratory.

New inductees to the American College of Surgeons: Honolulu—**Drs. Thomas S. Bennett, Raymond G. Chang, Carl B. Mason, Satoru Nishijima, Niall M. Scully.** Hilo—**Dr. Harold Lewis.**

To **Dr. and Mrs. Harry L. Arnold, Sr.,** who celebrated their golden wedding anniversary October 7.

Dr. Dean M. Walker, newly appointed first medical advisor to the State Workmen's Compensation Division.

Mr. Howard W. Pearce, new executive secretary to the HCMS. He formerly served at the San Joaquin County Medical Society and comes well recommended. Good luck, Howard!

Drs. Min Hin Li and **Chisato Hayashi,** directors of the new Pacific Guardian Insurance Company.

Drs. David Pang, A. Ng Kamsat, *et. al.*, for initiative in starting the Hale Nani Nursing Home.

Obituaries

The "grim reaper" keeps taking his toll of our colleagues. We note with sadness the loss of **Dr. C. J. Kusunoki** (ENT), who passed away very suddenly and unexpectedly at age 51.

Maui physicians lost a dear friend and colleague with the passing of long-time practitioner and sportsman, **Dr. E. S. Kushi.**

Hawaii County also suffered a great loss in **Dr. T. Kutsunai,** who after 30 years of practice, quietly passed away at The Queen's Hospital.

Of interest to the profession here was the news of the death of **Dr. I. McQuarrie** of Minnesota, formerly Director of Medical Education at Children's Hospital.

They will all be missed.

Travel News

Dr. L. Q. Pang recently presented papers at the AMA meeting in New York and to the Vienna State Hospital in Austria. He also visited clinics in Germany and attended the International Ophthalmological Society meeting in Paris. His wife Tita accompanied him.

Dr. and Mrs. Bob Millard left for a three-month tour of Europe. Bob will attend meetings in Vienna.

Dr. Rodney T. West took in the Ob-Gyn meeting in New York.

Major Shigeru Horio (reserve) attended the 14th Annual Symposium on pulmonary diseases at the Fitzsimons Hospital in Denver.

Dr. and Mrs. Harold Sexton spent time in Chicago and Mexico after meetings in New York.

A tour of South America was in store for **Dr. and Mrs. L. Clagett Beck.** Dr. Beck served as a delegate at the general assembly of the World Medical Association.

Dr. and Mrs. H. J. Lambert left for Yosemite and some sightseeing.

New Affiliations

Dr. Harold Y. Nekonishi (pediatrics) is in association with the Central Medical Clinic at 1481 So. King Street.

Dr. J. C. Carson is located in Kaneohe as **Dr. Fred Reppun's** new associate in general practice.

Dr. Charles T. H. Ching (internal medicine) has opened his office for solo practice at 1507 So. King Street.

Drs. Wallace W. S. Loui and **Florence J. Chinn** have moved to 1531 So. Beretania Street.

Drs. Verne C. Waite, R. S. Omura, and **C. S. Sakai** have relocated to the fifth floor at 1441 Kapiolani Blvd.

Dr. C. F. Chang and **Dr. Albert K. T. Ho** have also gone to 1441 Kapiolani Blvd.

The Dickson-Bell combine has made formal announcement. In their new offices on the fourth floor at 1441 Kapiolani Blvd. are **Drs. Dickson, Ed Cushnie, Chung-Hoon, D. B. Bell, John Bell, Oakley, Sinclair,** and later, **D. B. Bell II.**

Dr. Anna Marie Brault has joined the Medical Department of the Straub Clinic.





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ROSE ANN POYZER, *Executive Secretary*

*New Community Resource For The Disabled**

Disabled adults need not be completely dependent. No matter how seriously crippled, most of them can be helped to reach their maximum rehabilitation potential. They can be taught to care for their toilet needs, to move about home, and to feed or dress themselves. They can become independent of attendant care.

Based on this premise and the successful experience of some mainland communities, several agencies here, led by the Division of Vocational Rehabilitation, are sponsoring a special project to help disabled adults attain self-care ability in daily activities and where possible to become fully or partially self-supporting. The project called the Independent Living Project is one of several similar plans in the country supported partially by funds from the U.S. Office of Vocational Rehabilitation.

Working on the project are two teams. The project team consists of a physiatrist, Dr. R. F. Shepard; a coordinator, Mrs. D. Melleney; a Public Health Nurse, Mrs. Grace Smith; a physical therapist, Mrs. C. Dasinger; an occupational therapist, Mrs. D. Darmstandle; and a vocational rehabilitation councillor, Miss J. Nakasone, who also serves as the medical social worker. The second team is a consultation team composed of physicians. On this team are specialists in orthopedics, neurosurgery, psychiatry, internal medicine, physical medicine, and general practice. This panel provides medical direction to the project.

Patients referred for services are evaluated by the panel of physicians or by the project team to determine to what level of self-care they can be brought. Then, in consultation with the patient's physician, a treatment is outlined.

Treatment services are provided in the patient's home, nursing home, hospital, or the Rehabilitation Center of Hawaii, depending on the needs of the patient. Through the rehabilitation treatment phase, the patient remains under the supervision of his own physician.

To be eligible to the project the patient must (1) have the approval of the attending physician; (2) be over 21 years of age; (3) be chronically disabled by serious illness or accident; (4) be unable to carry out activities of daily living such as eating, dressing, personal hygiene, or just moving about; and (5) have foreseeable self-care goals.

Among those receiving help are a man, age 49, disabled due to a stroke and fractured femur, and a woman, age 56, crippled from rheumatoid arthritis. At the time the male patient was referred, he had been in a nursing home for three years with attendant care provided. After three months of treatment at the Rehabilitation Center and with the proper prosthesis and cane, he was placed in a boarding home, no longer needing nursing or attendant care. Whereas he might have required confinement indefinitely in a chronic illness facility, he is now able to care for his needs, including the financing of boarding care out of his monthly disability check.

The 56-year-old woman suffered from severe contracture of the fingers and knee at the time she was referred to the project team. She was so weak she could not manipulate her wheelchair. After four months of intensive treatment in a chronic disease facility, she learned to walk with crutches, was able to dress herself, cook, and do the dishes. A ramp was built to enable her to get from the street to her home. She is no longer dependent on her working daughter, with whom she now lives, for her daily needs. Both of these patients are continuing to be followed by the team to check on progress.

The rendering of rehabilitation services to individuals is only one phase of the project. It has as its main objective the demonstration of the value of comprehensive rehabilitation services to aid the disabled and chronically ill. The study of various aspects of community rehabilitation programs such as costs, methods, techniques, and goals is also another objective.

The program has accomplished much in the area of education for professional personnel working with the disabled. The evaluation sessions, conducted at the Queen's Hospital the first and third Thursdays of each month at 12:30 P.M. by

*Condensed from an article for the *Health Messenger* by Miss Marion Akamine.

the panel of physicians, have been effective in extending rehabilitation concepts into the private practice of medicine. Nurses and other paramedical people are all invited to attend when they are able.

The rehabilitation team, working with nursing home and hospital personnel in carrying out the recommendations on specific patients and in teaching rehabilitation procedures, helps to improve the rehabilitation capacity of these staff members. A three-week training course for supervising nurses was recently completed at Maluhia Hospital. These supervising nurses will in turn train their nurses and aides in rehabilitation techniques.

Similar training sessions are planned for nursing homes. Another important part of the project is the provision of consultation and advice on rehabilitation programs to institutions which have referred patients. Leahi and Maluhia hospitals and Aiea Heights Rest Home are among those institutions receiving such help.

Actively participating in the sponsorship of the project are the State Department of Health, the Rehabilitation Center of Hawaii, and the Hawaii Medical Association. The Chronic Disease Branch of the Department of Health has assigned a public health nurse to serve as nurse member of the project team. Also, this branch and the Rehabilitation Center of Hawaii are making the part-time services of a physiatrist available. The Rehabilitation Center of Hawaii is making office facilities available. The Hawaii Medical Association provides medical guidance. Physicans and others interested in referring patients should call:

Mrs. Doris Melleney, Coordinator
Independent Living Project
Division of Vocational Rehabilitation
Telephone: 586-437
or write to
Division of Vocational Rehabilitation
P. O. Box 2360
Honolulu, Hawaii

From 1900 to 1961 AJN Success Story

When the postman brings your crisp new copy of the latest *AJN*—and you leaf through deciding which article will be first to receive your attention —do you ever wonder *how it all started?*

It was just before the turn of the century that the newly-organized Associated Alumnae of Trained Nurses (predecessor to ANA) decided that the nursing profession needed its own journal. Determined that it be managed, edited and owned by nurses, the association appointed a committee "to consider ways and means of publishing a magazine to be the official organ of the society."

Chairman of this committee was Mary E. P. Davis, who became the driving force behind the establishment of the *AJN*. Committee members were Harriet Fulmer, M. Adelaide Nutting, Sophia F. Palmer, Isabel Hampton Robb, and Margaret W. Stevenson. All of these remarkable women had other professional responsibilities. Planning for the *Journal* had to be done in their spare time and mostly through correspondence!

The complete story of their early struggles to establish a firm foundation for what is now the American Journal of Nursing Company (publishing *The American Journal of Nursing, Nursing Outlook, and Nursing Research*) should make every nurse proud that the profession can claim such dedicated and visionary heroines. (*The Story of the Journal Company*—published in 1960 on the *Journal's* 60th birthday—can be requested free of charge from *AJN*.)

Here's How to Make New Section Choice

Looking for a section to call your own?

Neither title of position nor employing agency alone will assist you in choosing section membership appropriate to your area of nursing practice. Consider instead your functions and ANA section membership rules.

ANA section membership rules are based on area of practice and also provide for those nurses who have retired from active practice.

Rules of several sections were liberalized in 1960 so that some nurses will probably be eligible for membership in more than one. Within the limits set by the rules, these nurses may select membership in a section with which they most closely identify.

Most members of the former Special Groups Section may now choose new section affiliation without difficulty. For example—

Are you a professional employee of a state board of nursing? Then you should belong to EACT because a primary function is that of giving consultation on nursing education.

Are you on the executive staff of an American Red Cross Nursing Service? Then you are primarily concerned with providing public health nursing service, and you can join the Public Health Nurses Section.

If you are a guidance counselor in a school of nursing, your functions are related to nursing education, and you may join EACT.

If you are a registrar in either a professional or commercial nurses registry, you are eligible for membership in the new CESR Section.

Are you employed to give intravenous, oxygen, or allergy therapy? Do you work in intensive care or neuropsychiatric units? You may choose to join

either the Nursing Service Administrators or General Duty Nurses Section depending on your functional role.

Writers and editors of nursing or health journals are eligible to join EACT.

Nurses in hospital libraries, housekeeping departments, dietary services, and record rooms are not considered to be in active nursing practice. If you are so employed, then you should join the section corresponding to your last employment in nursing.

Mary M. Roberts Fellowship

Effective at once, the Fellowship Committee of the American Journal of Nursing Company is accepting applications for the 1962 Mary M. Roberts Fellowship in Journalism. The deadline is February 1, 1962.

The Fellowship is awarded on competitive basis. Applicants, who must be members of the American Nurses' Association, between 25 and 55 years of age and with a baccalaureate degree, are asked to prepare and submit an original manuscript on a subject of significance to nursing.

The award winner receives a one-year study program at a recognized school of journalism and up to $3000 to help defray expenses beyond tuition. After the year of study is completed, the winner is also offered a three-to-six-month internship on the editorial staff of the American Journal of Nursing Company.

Established to provide specialized training in journalism to nurses with writing talent, the Fellowship is a tribute to the late Mary M. Roberts, editor emeritus of the *American Journal of Nursing*.

For complete details of the competition and application forms, interested nurses are urged to write: Mary M. Roberts Fellowship Committee, American Journal of Nursing Company, 10 Columbus Circle, New York 19, N. Y.

Shortage of Nurses?

The term "shortage of nurses" has become "almost proverbial" tending to overemphasize numbers at the expense of other factors involved in the problem, according to the 1961 edition of *Facts About Nursing*, just published by the American Nurses' Association.

Most measures of need are based on ratios of personnel to population, the publication notes, rather than on the number and kinds of personnel which best meet the needs of patients and others requiring health care. Very little research has been done on that qualitative aspect of nursing care.

Numbers of professional nurses are increasing proportionately much faster than the population. The estimated 504,000 professional nurses employed in the United States in 1960 reflect an increase over the past ten years almost double that of the increase in population. This total includes at least 90,000 nurses who are working only part time.

Facts suggests that the return of inactive nurses to the profession, either full or part time, may be one partial solution to the so-called shortage. Other solutions are "better and perhaps different utilization of nursing personnel and improvement of educational preparation" as well as continued efforts to attract qualified young people into the field.

Though the majority of nursing students still receive their basic preparation in hospital schools of nursing, there has been a steady rise in the numbers receiving basic education in colleges or universities, and more nurses are obtaining advanced education. Graduate nurse students granted academic degrees in nursing in 1960 totalled 3,723 compared to 2,317 in 1951.

At present, the publication states, less than two per cent of employed professional nurses have master's degrees and only about seven per cent have baccalaureate degrees.

About 99 per cent of registered nurses are women, and 54 per cent of them are less than 40 years old, the publication reports. The majority are married; only about 31 per cent are single.

New data on salaries and employment conditions of nurse educators shows a median annual salary of $5,150 for teachers and administrators in professional educational programs. Median starting salary for a teacher with a baccalaureate degree is $4,500.

Results of 1960 surveys conducted by the U.S. Bureau of Labor Statistics in 15 metropolitan areas and reported in *Facts*, show weekly salaries of general duty nurses in nongovernmental hospitals ranging from $67 in Atlanta to $85 in Chicago and Los Angeles-Long Beach. Those in top nursing positions—directors of nursing services—received weekly earnings varying from $97 in Cincinnati to $152 in San Francisco-Oakland.

Facts About Nursing is the most comprehensive sourcebook published of facts and figures on nurses and nursing. It includes information on national distribution of professional nurses, education, economic status, and data on allied nursing personnel.

Nurse Volunteers Urgently Needed For National Defense

The American Nurses' Association is cooperating with the military services nurse corps in their current efforts to reach and maintain the strength

necessary to support increased military needs called for by President Kennedy.

All members will be interested in the following information concerning current nursing requirements of the armed services:

Army Nurse Corps: The Office of the Surgeon General reports "an immediate critical need for 500 additional nurses to sustain our medical care program. Expansion of the Army and stepped-up training means more soldier patients and the strength of the Army Nurse Corps must keep pace." The army hopes to meet the immediate requirements through volunteer nurses, mainly young women and men who have not yet served in the Armed Forces. By obtaining volunteers, they feel a more serious disruption of civilian and government hospitals can be avoided. Many of the reservists subject to recall hold key positions in these hospitals. "The greatest need is for general duty nurses," said Lieutenant General Leonard D. Heaton, Army Surgeon General. "Critical requirements also exist for qualified individuals in the clinical fields of operating room anesthesia, and neuro-psychiatry. Inquiries should be addressed to Colonel Carrie E. Barrett, ANC, Chief, Nursing Service, U.S. Army, Tripler General Hospital, or to the Office of the Surgeon General, U.S. Army Nurse Corps, Washington 25, D. C.

Air Force Nurse Corps: Nurse volunteers are needed, although the number has not been specified. Principal utilization, it is anticipated, will be in general staff nurse positions. Inquiries should be addressed to Air Force Nurse Corps, Office of Surgeon General, Headquarters, USAF, Washington 25, D. C.

Navy Nurse Corps: At present the Navy Nurse Corps does not have an allowance for additional input of Navy Nurse officers. Inquiries should be addressed to Director of Navy Nurse Corps, Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

No history of war or campaign for national preparedness involving the United States would ever be complete without mention of the vital role played by the American nurse. Professional nurses have always rallied in gratifying numbers to the service of their country in time of need or crisis. Reflecting this attitude on the part of their members, national nursing organizations have increasingly concerned themselves with the problem of providing and training nurse manpower to meet emergency demand.

American Nurses' Association activities toward that end during World War II and the Korean conflict culminated in 1950 with the appointment by the ANA Board of Directors of a special committee on nursing resources and military nursing needs. In 1953 the name of this committee was changed to the ANA Special Committee on Nursing in National Defense. The committee has prepared and brought up to date a statement of assumptions, purposes, and functions and in 1960 issued the document, *The Role of the Nurse in Disaster*. It has also been responsible for arranging conferences with the U.S. Office of Civil and Defense Mobilization and allied agencies, special CD courses for nurses, and programming meetings on disaster nursing at ANA conventions.

A Time of Decision

An important decision delegates to ANA's 1962 convention will be asked to make is whether or not to increase ANA dues from $7.50 to $12.50, effective January 1, 1963. All ANA members will want to give the question serious thought and make their opinions known to the delegates representing them.

Why does the ANA Board of Directors believe that a dues increase will be necessary by 1963? A 59 per cent increase over the past three years in the costs to ANA of basic operations (rent, electricity, utilities, insurance, postage, dues to other organizations, salaries, etc.) is only one factor. The most important consideration is the vital need for a stepped-up program—the expansion of services to each nurse, to the profession as a whole and to society. A stronger, more influential professional organization is a must if nursing is to meet its responsibility in regard to the expansion and improvement of health care.

It is a time of opportunity. Health care has increasingly become a topic of major national concern. Nursing, as the largest health profession in the country, must be ready to contribute to decisions that will be made about patient care. Professional nurses have everything to gain—improvement of individual practice and professional status, more equitable remuneration, and a sense of satisfaction for having been instrumental in achieving higher standards of professional practice for better patient care. This is a crucial period for nursing. ANA, as the professional association, must take steps now to ensure nursing's progress. And it must have the resources and facilities to do the job—to take the lead; to be the voice of professional nursing.

What are some of the new programs, expanded activities that are needed?

(1) An expanded program of clinical emphasis. More conferences and institutes, geared to the interests of members in all clinical areas, held in different parts of the country so that all members can easily attend.

(2) Establishment of official standards of nursing service and education which would allow nurses to function more effectively and ensure the most effective utilization of professional skills and knowledge.

(3) An expansion of ANA contacts with federal government officials, health groups, other national and international organizations and the public.

(4) An increase in contacts with opinion-making media (the daily press, magazines, radio, and television) in order to tell nursing's story to the general public.

(5) Additional emphasis on research to supply nurses with guidance for improving nursing service and education.

(6) More guidance and counsel for nurses seeking to improve economic and working conditions.

(7) More direct assistance from ANA to state nurses associations and thus to members through expanded and specialized field service.

(8) A more convenient, centralized method of dues collection with possible installment plan of payment.

All of these things are now under consideration. However, they require much greater resources than ANA now has.

Is a stronger profession, a more vital association important to you? Is your future in nursing a matter of real interest and concern? ANA members must make the decision now—for themselves and for the future of professional nursing.

American Nurses Foundation

During the past year, most states have been engaged in fund raising activities for the $1 million campaign of the American Nurses' Foundation. Campaign plans were announced at last year's state annual meetings. This year, some ANF state co-chairmen will report on their state and district campaign progress during the meetings.

Mrs. Katharine Densford Dreves, the National Campaign Co-Chairman, and Miss Agnes E. M. Anderson, ANF President, have urged that each ANA and ANF representative who attends state annual meetings should give a brief progress report on the ANF campaign.

Miss Phyllis A. Toner, the campaign director, will help you with any information you need for your presentation. We very much appreciate your good help.

The national campaign seeking a minimum of $1 million for an expanded research in nursing program of the American Nurses' Foundation has been under way for a year. To reach state campaign quotas, the state and district nurses' associations have adopted a slogan of "Give or Get $5" for each member.

Six committees have already exceeded their quotas: Delaware, Hawaii, Maine, Oklahoma, South Dakota, and the Virgin Islands.

Sixteen more states have secured 50 per cent or more of their campaign quotas: Alaska, Arkansas, District of Columbia, Georgia, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Montana, Nebraska, North Carolina, North Dakota, Virgina, West Virginia.

This state is among the leaders! We are hoping that all states will report 100 per cent at the 1962 ANA Biennial Convention in Detroit.

Campaign receipts now total $350,000 and they represent the outstanding efforts exerted by over 20,000 nurses who are serving on 47 campaign committees across the nation. Nurses have responded to the national appeal by giving unsparingly of their valuable time, energy, and financial resources. Warmest thanks is expressed to them, for without their help this progress report would not be possible.

The funds secured have enabled the Foundation to begin parts of its expanded program in the form of research grants, consultant and information services.

The first research grant has been awarded to Rancho Los Amigos Hospital in Downey, California, for a year's study of nursing in relation to the rehabilitation of incontinent elderly patients.

Research consultant services have begun with the appointment of Dr. Myrtle Irene Brown, R.N., as research consultant in nursing. Dr. Brown will travel across the country to discuss research findings and to guide nursing leaders in research projects.

The first monograph—made possible by campaign funds—appeared in August. It is a report by the Boston University Human Relations Center staff on an outpatient nursing study which started under an ANF grant.

The Foundation is beginning a service for abstracting reports of nursing research.

ANF staff will report at workshops in Indiana and Michigan in October on the public health nursing study of ANF. The staff will present a report on ANF's cardiac nursing project at the convention of the American Heart Association at Miami Beach, Florida, in October.

And this is just the beginning of a series of programs which mean better nursing care through research. There is help you can give to the Foundation. If you have not made your contribution to ANF, you are urged to do so now. Also, if you know of anyone who may be interested in supporting this program, try to encourage a gift to the ANF campaign. Perhaps you can serve on your district campaign committee. Simply let your state leaders know of your interest. We nurses have most at stake in ANF's expanded program and we welcome your help wholeheartedly!

* * *

The Dynamic Nurse-Patient Relationship

By Ida Jean Orlando, R.N., M.A., 91 pp., $2.00, G. P. Putnam & Sons, 1961.

The National Institute of Mental Health of the U.S. Public Health Service awarded a five-year project grant to the Yale University School of Nursing in 1954. This is a report of the study.

I believe that this book very adequately fulfills the purpose for which it was written—to offer the professional nursing student a theory of effective nursing practice. An application of this theory will help her develop her professional role and identity. Actual case situations are given to examine and further help the reader to identify professional nursing function. An analysis of the nursing situation is made, and the principles of effective nursing practice are then formulated.

The theory advocated in this book can be most helpful and warrants further investigation by nurses.

(Mrs.) Rose Ann Poyzer, R.N.

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

BERYL UYEHARA, *Editor* MAX BOWMAN, *Associate Editor*

October Meeting

The HMTS members, at their October dinner meeting, were honored with the presence of guest speaker, Dr. Donald A. Nickerson of Salem Hospital, Salem, Massachusetts, who spoke on the different uses of radioactive isotopes. Dr. Nickerson was recently elected President of the American College of Pathology.

Many thanks to Louise Wulff and her crew who were in charge of the arrangements. They donated their time to sew leis, greet the incoming pathologists at the airport, and help out at the Filipino festival.

*Prove and Improve Your Blood Bank**

In the relatively short period of time that blood transfusions have become of major importance in the field of medicine, much has been done to analyze the component parts of whole blood to give full significance to the word "compatibility." Compatibility is defined as the capability of existing together, a definition which is simple in meaning but sometimes complex in its execution. It is indeed the most significant of all terms applied to blood banking. Whether the question at hand involves one or 100 transfusions, from the newborn to the aging patient, compatibility means life.

We must encourage and support all blood banking societies in order to acknowledge the boundless research that is making knowns of unknowns, and we must acquaint ourselves with the problems that are being encountered all over the world. Pasteur stated in 1873, "The benefits of science are not for science but for humanity." A technologist must never feel that nothing exciting ever happens in his blood bank.

Today there are many reference laboratories willing and anxious to help us with our problem bloods. There are meetings and discussions on techniques, protocol, new factors, new theories; there are films, bulletins, journals, and books containing excellent material vital to every blood bank laboratory. These are the contributions that will help "prove and improve your blood bank."

The problem I would like to discuss concerns the most basic of all blood banking procedures, that of ABO grouping. According to statistical reports, ABO incompatibility reactions occur at a rate of 1 per 4000 transfusions. Laboratory standards are higher than ever before and grouping serum has never been more specific or avid; yet, technical errors in relation to the ABO system, as well as clerical errors, have gradually increased. A blood sugar may, by one method, be estimated at 80 mg%, and by another, 120 mg%; a white blood count of 11,900 may, after being repeated, be 10,800; or a urine culture may be said to contain E. coli when actually it contains Aerobacter aerogenes. These discrepancies are relatively insignificant in the diagnosis and treatment of the patient. Yet, can we, in the same breath, say that a patient may be group A by one method and group O by another? In our field there can be no average or compromise. The following paragraphs will reveal some observations, a few experiences, and my own impressions of how we all help to improve the standards of blood banking from both the technical and clinical points of view.

Despite state rules and regulations, many blood banks continue to omit back-typing on all blood specimens. It is the opinion of some that the use of group O serum is adequate as a check on the direct grouping method of known anti-sera and unknown cells. My impression is, however, that although this serum is a valid test for screening O individuals, it must not be substituted for the standard back-typing procedure using known A and B cells against unknown sera. If X cells are not agglutinated by group O serum, these cells are then classified by many as type O. On the other hand, if the cells are agglutinated, they may be classified as either A, B, or AB. This means that approximately 45 per cent of all groupings are being confirmed and about 55 per cent are almost completely dependent upon the direct method. Back-typing not only confirms the direct grouping method, but in addition reveals the existence of weak sub-groups of A. It also detects the absence of iso-agglutinins normally present in plasma, a condition in which agammaglobulinemia may be suspected. Group AB individuals are the exception since they normally lack anti-A and anti-B agglutinins.

In many hospitals repeat blood donors and pa-

* Reprinted from the Massachusetts Journal of Medical Technology. Fall 1960, Volume 3, Number 1.

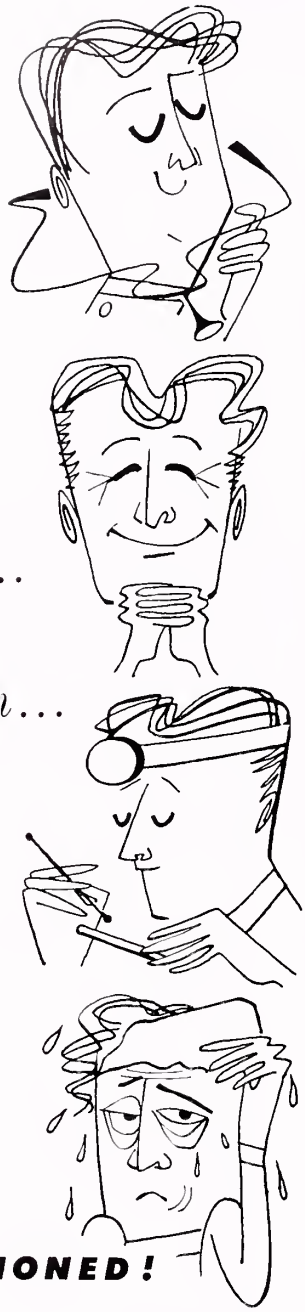
tients, who are readmitted to the hospital, are not regrouped. Old files are being referred to and these new blood specimens are being classified on the basis of records of their last donation or admission only. I strongly recommend the reference to previous information on donors and patients; however, not without correlating the actual grouping of the fresh specimen with the grouping indicated on the record.

I will cite an experience to stress the importance of the statement I have just made. I was recently given a sample specimen of blood on a patient who had been transfused at our hospital a year ago. I grouped the new specimen as B Rh positive, and then referred to her previous card. This card stated that she was O Rh negative. My first impulse was to obtain another specimen from the patient, who was situated in a semi-private room. When I told her I had come to take blood from her arm, she said that she had been expecting me. She said that a tubeful of blood had been taken from the woman in the next bed and that she had expected someone would soon be taking hers. The sample I had drawn from the correct patient was group O Rh negative, and her roommate, on whom no orders had been written, was group B Rh positive. This, of course, was gross negligence and inexcusable since our outlined methods of patient identification are extremely thorough. Everyone has the following unequivocal identifying information available to him: (1) a stamped blood bank requisition stating the patient's complete name, case number, service, ward date of admission, and room number; (2) a prelabeled tube bearing the patient's full name, case number, ward, and date; (3) a wrist band with the same information; (4) a card at the head of the patient's bed again with this information, including her home address; and (5) her chart at the foot of the bed. With all of this, we received blood from the wrong patient. My point here is not to condemn or exaggerate the carelessness of any hospital personnel, but rather to demonstrate a human error that with every conceivable precaution was still committed. This patient received nine blood transfusions in the operating room. Here the reference to her previous card unquestionably saved her life.

Just recently I learned of a blood donor who had been donating blood faithfully at a well-known hospital since 1947. He was grouped as A Rh positive, and all records indicated that his blood had been given to A Rh positive recipients. Quite by chance, a student selected a number of random specimens on which to practice his technique on back-typings, that is, using unknown sera against known A and B cells. Upon checking the records to confirm his results, he found the serum of the faithful 1947 blood donor had strongly agglutinated both A and B cells. When he tested the cells against anti-A and anti-B sera, he found no agglutination. Much to the embarrassment of the chief technician, the donor was recalled, regrouped, and reclassified as group O. The routine cross-matching procedure consisted only of the major tube, so that, obviously, with this method, it was impossible to observe any minor incompatibilities. The importance and primary function of the minor cross-match is to determine homologous blood group compatibility. The minor tube must never be omitted in the cross-matching technique.

Another routine that should be strictly adhered to is the regrouping of bloods borrowed from other institutions and national organizations. How tempting it is to accept bottles and pilot tubes with the blood group neatly labeled in bold print. Yet, in our experience, we have found that two per cent of our bloods acquired from outside sources have been erroneously grouped. I would like to qualify a statement I made concerning neatly labeled blood bottles and pilot tubes. Unfortunately, there is no uniform tagging system for blood identification, and so, as a result, tags vary in size, shape, color, and information. Each blood bank, is, of course, accustomed to its own system, but occasionally we are overtaken by the monotonous routine of labeling these bottled and pilot tubes, and we tend to become careless in their identification. Recently, to demonstrate my point, we borrowed a unit of blood that had two stickers on it, one labeled A and the other O. There is no excuse for illegibility and incomplete information on donor tags. Groupings should never be corrected on labels. For example, an O should never be converted to an A, or an A to a B. Rather an entirely new label should be prepared and the incorrect one removed and destroyed. Grossly hemolyzed pilot tubes are unsatisfactory for accurate compatibility testing and should not be used. If dried blood covers any part of the donor tube number, the label should be made over without question. Guesswork is conducive to errors, and errors to fatalities. In conclusion, it can be seen that much depends upon the role of the technologist. His absolute attentiveness to the simple practices or routine procedure in existence in his hospital, and his insistence on this same attention by all other persons involved in blood transfusions, will assure the highest standards of safety to the patient and the greatest returns of efficiency to his hospital.

IDA MALOOTIAN, B.B. (ASCP), *Supervisor*
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COUNTY SOCIETY REPORTS

(Continued from page 152)

the HCMS and HMSA is being negotiated at the staff level, (2) that we can treat HMSA like any other insurance company, (3) we can make a new contract, or (4) we can suggest that the State Association take over the contract negotiations on a state level. The Chair also called on several doctors present to express their opinions on the matter.

A lengthy discussion followed during which Dr. Ando proposed the following resolution and moved "that the HCMS reaffirms to its membership that the approval of HMSA as a Blue Shield Plan and the signing of individual contracts with HMSA be deferred until negotiations by our Society are concluded with HMSA to the general satisfaction of the Society." The motion was seconded. Following further discussion, Dr. Ando's resolution was voted on and was carried. In answer to a question as to what the Society plans to negotiate in the new contract the Chair read off a list of tentative proposals. It was suggested to the negotiating body that they should obtain something that is equitable to all and that the advice of expert council be used in every step of the negotiations.

* * *

The Honolulu County Medical Society met on August 29, 1961, in the Mabel Smyth Auditorium. Approximately 132 members were present. Also present were Dr. Burden, HMA President, and Tom Rice, HCMS attorney.

The Medical Care Plans Committee report to the Board of Governors recommending the approval of the individual contracts between the physicians and HMSA, and the contract between the Medical Society and HMSA as distributed this evening was read by Dr. Hartwell. Dr. Hartwell also stated that there was no recommendation from the Board of Governors. Mr. Richard Kennedy reviewed some of the highlights of the negotiations which took place between HMSA and HCMS representatives, and Mr. Tom Rice commented on the many aspects of contract negotiations. A question and answer period followed.

A motion that item 5 of the Application for Participating Physician Membership in HMSA as circulated be amended to include the words, "of the Medical Committee" between "designated representatives" and "to examine any of my records," was made by Dr. Herbert Chinn, and motion was seconded. Motion did not pass. Ballot result was 63 No and 62 Yes.

Dr. Liljestrand moved that the proposed drafts as distributed be approved. Motion was seconded and carried.

* * *

The Honolulu County Medical Society met on September 12, 1961, at 7:30 P.M. in the Mabel Smyth Auditorium. Approximately 60 members were present.

Robert Nordyke, M.D. spoke on "Nuclear Medicine: Diagnosis and Treatment."

New members introduced by President Hartwell were Drs. Ira Hirschy, Royal De Lany, and Henry H. Y. Yim.

Dr. O. D. Pinkerton read a resolution in honor of Dr. C. J. Kusunoki, recently deceased.

The resolution was unanimously passed. A moment of standing silence was observed.

Dr. Hartwell presented the recommendation of the Board of Governors that Dr. Y. S. Seto be granted life membership. A motion to grant life membership to Y. S. Seto, M.D., was made, seconded, and passed.

(Continued on page 172)

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References: 1. Sturgeon, P., in Wallerstein, R. O., and Mettier, S. R.: Iron in Clinical Medicine, Los Angeles, University of California Press, 1958, p. 183. **2.** Smith, N. J., and Schulz, J., op cit., p. 65.

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3.	ADDITIONAL CHARGES	(+)	
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5.	DISCOUNTS ON TODAY'S SERVICES	(—)	5.00-
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7.	TOTAL OUTSTANDING TO DATE	(*)	14,360.00*←
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8.	TODAY'S RECEIPTS (ACTIVE ACCOUNTS)	(+)	120.50
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11.	FEES CHARGED TO PATIENT'S ACCOUNTS TODAY	(+)	135.00
12.	DISCOUNTS ON TODAY'S SERVICES	(—)	5.00-
13.	NET FEES FOR TODAY'S SERVICES	(*)	130.00*←

		FEES CHARGED	RECEIPTS
CURRENT MONTH'S BUSINESS			
14.	PREVIOUS DAY'S TOTAL	705.50	642.00
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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COUNTY SOCIETY REPORTS

(Continued from page 166)

Dr. Hartwell read Dr. Moore's letter of resignation as Secretary. Dr. Moore will serve as Secretary until the coming annual meeting.

R. M. Kennedy introduced Howard Pearce, the new executive secretary. A lei was presented by Mrs. Lois Lucas, President of the Woman's Auxiliary. Mr. Pearce gave a brief talk.

President Hartwell gave a farewell message to Mr. Kennedy who will leave the Society. A lei was presented by Mrs. Lucas. Mr. Kennedy gave a brief aloha message.

Two recommendations he left for the Society were: (1) That the Society have a negotiation committee which is appointed to negotiate fee schedules and contracts, and (2) that Hawaii Medical Association take a more mature role and assume rightful statewide projects.

Dr. Arnold, Jr. appealed to the members to make reasonable contributions to the Community Chest.

A detailed progress report on the work of the PR Committee was presented by Dr. Wm. Stevens.

A. S. HARTWELL, M.D. for
R. D. MOORE, M.D., *Secretary*

Kauai

The regular monthly meeting of the Kauai County Medical Society was held in the library of the G. N. Wilcox Memorial Hospital on August 1, 1961. The meeting was called to order by Dr. Cockett, President, at 7:40 P.M. Dr. J. A. Burden, President of the Hawaii Medical Association, was present as guest speaker.

Dr. Burden discussed the various factors involving the HMSA, the State Association and the Honolulu County Society. He then reported on the American Medical Association Annual Meeting.

Dr. Burden also spoke on Workmen's Compensation in Hawaii and present negotiations for a new fee schedule.

The question of Social Security requests was brought up which involved a physical examination and the completion of a report. It was unanimously agreed that a charge of $5.00 should be made for this.

* * *

The regular meeting of the Kauai County Medical Society was called to order by Dr. Cockett, President, at 8:45 P.M. on September 5, 1961, at the G. N. Wilcox Memorial Hospital Library in Lihue, Kauai. Dr. Mary Wicks of the Bureau of Mental Health was present as guest.

A letter from Mr. Morris Shinsato, attorney, was read in reference to a medical payment program for County pensioners and their dependents. Dr. Boido stated that the Board of Supervisors of Kauai County accepted the HMSA fee schedule. He also stated that due to a lack of secretarial help, the County could not make payments for the present and the near future.

Dr. Cockett presented and discussed the new HMSA Contracts. It was moved by Dr. Boyden and seconded by Dr. Kim that the above be accepted. All members present approved. Dr. Boido moved that the Kauai County Medical Society instruct its delegate to inform the HMSA that we prefer to have an equal number or greater number of Medical Directors from all Counties on the Board of Directors of the HMSA as compared to non-medical directors now present on this Board. This was seconded by Dr. Herter and carried by a majority vote.

A letter from Dr. Rodney West, Secretary of the Hawaii Medical Association on the present status of Dr. Worth's membership was read. It was moved, seconded and carried that Dr. Worth be placed on an inactive status with dues waived.

Dr. Peter Kim spoke about the Diabetic Drive which will be held on Kauai from November 12 to 18, 1961. It was moved, seconded and carried that the Kauai County Medical Society donate $20.00 for the purchase of diabetic detection kits for display and usage.

W. W. GOODHUE, M.D.
Secretary-Treasurer

Maui

A dinner meeting of the Maui County Medical Society was held at 6:30 P.M., December 20, 1960, at the Vineyard Chop Suey House.

Delegate to HMSA, Dr. Tompkins, reported that the performance in Molokai was again far above average and that the plan is being wrecked. Dr. Moran also reported similar irregularities with regard to the U. S. Life Medical Plan. Much discussion followed, however, no action was taken at this time.

The Nominating Committee presented the following slate for 1961:

DR. SEIYA OHATA.....*President*
DR. WILLIAM E. IACONETTI.....*Vice President*
DR. CLIFFORD F. MORAN.....*Secretary-Treasurer*

(Continued on page 174)

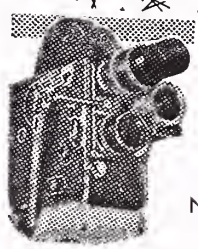
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COUNTY SOCIETY REPORTS

(Continued from page 172)

Dr. McArthur moved and Dr. Sanders seconded that nomination be closed and the secretary be instructed to cast a unanimous vote. Passed.

The committee of three, consisting of Dr. Shimokawa, Dr. Tompkins and Dr. Burden, who were appointed to investigate HMSA irregularities on the part of a member, reported that they were unable to put their fingers on anything and therefore unable to make recommendations. Inasmuch as a thorough investigation was not made, the chair instructed the committee they should do so and be prepared to report at the next meeting.

Dr. Burden moved and Dr. Iaconetti seconded that Dr. Tompkins be reappointed as Delegate to HMSA and Dr. Sanders be appointed first alternate and Dr. Underwood be the second alternate. Passed.

* * *

A special meeting of the Maui County Medical Society was held at the Wailuku Hotel at 8:00 P.M. on Friday, March 24, 1961. Guests present were: Doctors Bowles, Edgar, Goto, Kaiser, and Wallis.

Dr. Goto presented an interesting case. The diagnosis is a moot one. However, the possibility of barbiturate withdrawal and porphyria is good. Dr. Kaiser gave a talk on treatment of hyperemesis gravidarum.

A movie, "Resuscitation of the Newborn," was shown.

The President announced that the Department of Health has available two EENT men, Doctors Pang and Fraser, to conduct an otology clinic and to be on our program. Dr. Kliewer made a motion which was seconded by Dr. Sanders that two local otologists be utilized instead of having outside M.D.'s for local clinics.

* * *

The Maui County Medical Society held their regularly scheduled meeting on April 18, 1961 at the Wailuku Hotel. One guest was present, Dr. Wallis.

The Society was entertained by the Hawaii Medical Service Association who were represented by Mr. C. T. Oliphant, President; Mr. Joseph Veltmann, Executive Vice President; and Mr. Albert Yuen, Treasurer. Other guests were Dr. Robert Faus, Mrs. Charlotte Mochizuki, and Mrs. Louise Smith.

A very interesting discussion of different HMSA plans was undertaken by Dr. Burden, Mr. Veltmann, and Mr. Yuen after a brief introduction by Mr. Oliphant.

C. F. MORAN, M.D.
Secretary-Treasurer

BOOK REVIEWS

(Continued from page 153)

and phonocardiography were discussed, including some of the newer studies on intracardiac phonocardiography which I felt were most enlightening. Vectorcardiography was again discussed; I did not feel that this lends itself particularly to the everyday practice of cardiology. There were several chapters devoted to cardiac catheterization, newer methods of localizing shunts, and angiocardiography, particularly selective angiocardiography.

The last chapters dealt with open heart surgery, discussing the role of the anesthesiologist, the various pump oxygenators, and the postoperative care. These were most informative and gave one a rather well-written picture of this whole new field.

This book should be in the library of every cardiologist and cardiac surgeon. Also, the general practitioner would find the topics discussed here educational and interesting.

ELMER C. JOHNSON, M.D.

English for the Foreign Physician

By J. M. Martins, M.D., 121 pp., $5.75, Charles C. Thomas, 1960.

From time immemorial, the language barrier has been one of the major problems of the human race. From time to time, people have tried to create or establish an international language that could be used by all. Others have tried to simplify and streamline existing languages to make it easy for others to use. Such a work is "English For The Foreign Physician." This book is divided into five basic sections: Conversation, Abbreviation, Vocabulary, Questions and Exercise. Each chapter is devoted to one of the medical services, such as, "General Medicine Ward Round," "Chart Conference in the Chest Service," "GI Conference," etc. The author has tried to use the phrases and vocabulary peculiar to the particular service.

The need for such a publication has been felt for a long time—not only for foreign physicians, but also for our own interns, residents, nurses, technicians, as well as the administrative staff of hospitals.

It is a monumental task to compile a book of this nature that will be suitable for people from many lands and many language backgrounds. Since the Second World War, English has become more or less the scientific language of the world. However, many nations still use Latin and French. Therefore, if the definition in the

(Continued on page 176)

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Isolyte® M Maintenance with 5% Dextrose For routine maintenance in adults and older children	50	40	35	—	—	—	40	20	—	—	15	180	400
Isolyte P Pediatric Maintenance For routine maintenance in infants and younger children	50	25	20	—	3	—	22	23	—	—	3	180	350
Isolyte E Extracellular Replacement in Water For replacement of intravascular, interstitial, transcellular losses other than gastric	—	140	10	5	3	—	103	—	47	8	—	10	320
Isolyte E Extracellular Replacement with 5% Dextrose For use as above	50	140	10	5	3	—	103	—	47	8	—	180	570
Isolyte G Gastric Replacement with 10% Dextrose For replacement of gastric loss due to suction or vomiting	100	63	17	—	—	70	150	—	—	—	—	340	800
Also 2 New Potassium Solutions: **Kadalex® L** (20 mEq. K^+ and Cl^-/L.) 0.15% Potassium Chloride with 5% Dextrose in Water	50	—	20	—	—	—	20	—	—	—	—	170	290
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BOOK REVIEWS

(Continued from page 174)

Abbreviation and Vocabulary sections were in more internationally known and accepted phrases, they would better serve their purpose.

The value of Questions and Exercise sections is doubtful. Not many of the foreign physicians with a language handicap could take the time from their already crowded schedule to answer the questions and do the exercises; and who would supervise their work? Such an undertaking needs classroom atmosphere and a well-planned schedule. The usefulness of this publication could be increased many fold if there were added a section devoted to the vocabulary and the abbreviations listed alphabetically.

TOMIC T. ROMSON, MHA

★Handbook of Pediatrics, 4th Ed.

By Henry K. Silver, M.D., 574 pp., $3.50 Lange Medical Publications, 1961.

In the Navy they say that if you can't eventually find the answer in "Navy Regs," it can't happen. In pediatrics they say that if you can't find a condensed answer quickly in the *Handbook of Pediatrics* by the three Henrys (Henry K. Silver, C. Henry Kempe, and Henry B. Bruyn), there is no such thing.

Anyway, our friends in Denver, Colorado, have produced a fine, quick reference book full of all sorts of tables of laboratory data, differential diagnosis, normal values, etc. Diseases are grouped under the organ or system involved, as well as in general classifications, such as allergic, infectious, metabolic, endocrine, neoplastic, collagen, development, prematurity, adolescence, etc. Each disease is outlined under headings, such as etiology, clinical findings, treatment, prognosis, laboratory data, etc.

This Fourth Edition is a practical, up-to-date, pocket sized (7 x 4 x 1 inch) reference book for anyone interested in pediatrics.

W. A. MEYERS, M.D.

★Symptom Diagnosis, 5th Ed.

By Wallace Mason Yater, A.B., M.D., M.S. (in Med), F.A.C.P., and William Francis Oliver, B.S., M.D., F.A.C.P., 1035 pp., $15.00, Appleton-Century-Crofts, 5th ed., 1961.

The 5th edition of "Symptom Diagnosis" brings up to date a book that in the past has enjoyed an excellent reception. The purpose of this volume is to offer easy diagnostic aids without overlooking many differential possibilities. It does this by outlining diseases associated with regional symptoms. There is in addition, an excellent table of differential diagnosis of many common medical conditions.

The authors are both experienced teachers and in presenting this revision have made many additions. This volume is an excellent reference book for the hospital admission or emergency sections as well as for the busy practitioner.

The front of this book contains specific instructions on how to make the best use of this diagnostic guide.

The seven-page appendix is divided into two sections.

(Continued on page 180)



Dr. Steele Stewart

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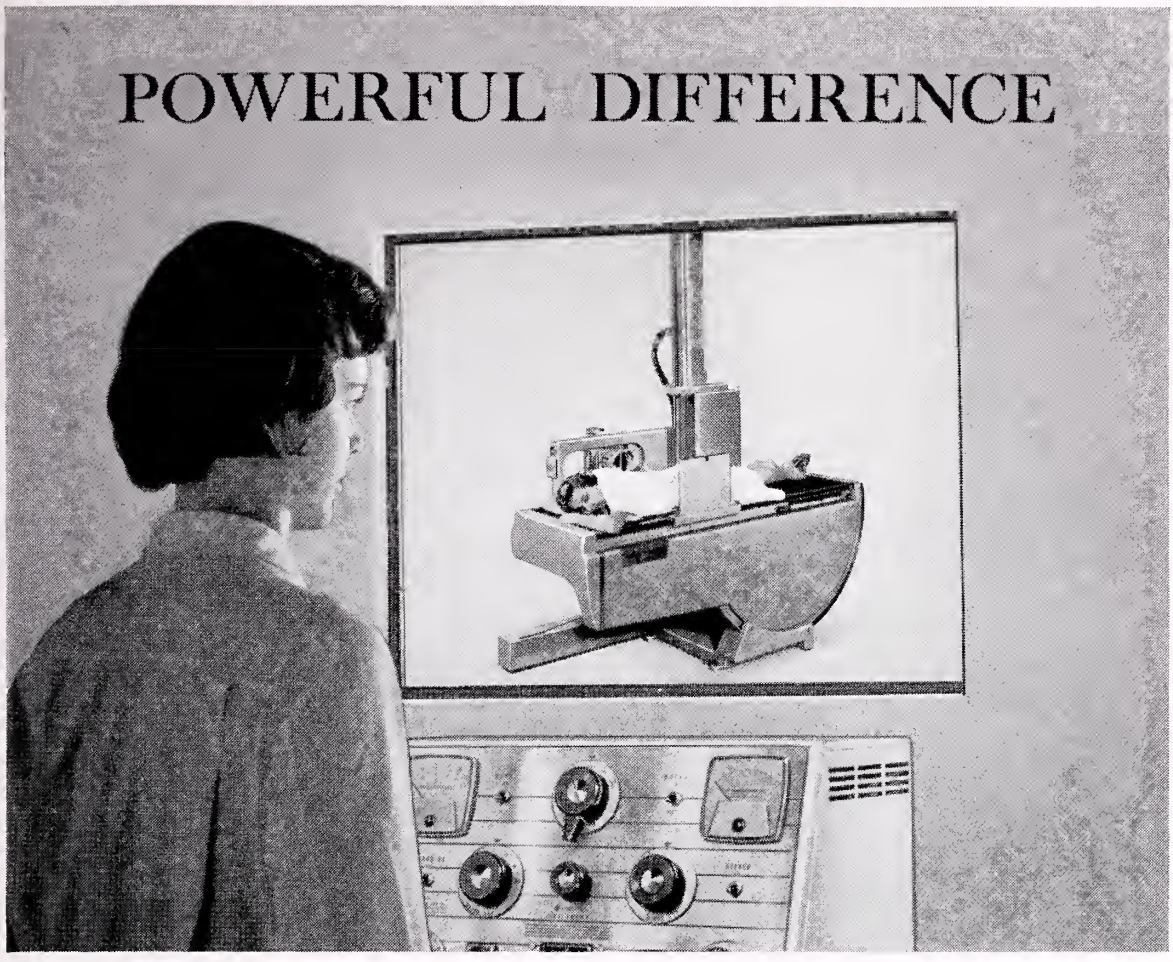
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BOOK REVIEWS

(Continued from page 176)

In part one, common syndromes are defined. The second section is made up of diseases and signs associated with men's names.

This well presented reference book contains 1,035 pages with a complete index.

HENRY GOTSHALK, M.D.

Chest Pain, Systematic Differentiation and Treatment

By Nathan E. Reich and Rudolph E. Fremont, 366 pp., $9.00, The Macmillan Co., 1961.

A review of this short book would be good for every practicing physician, lest he fall into the present-day fear of the laity that every pain in the chest is due to either a coronary attack or a lung cancer. The complaint is common enough and the patient is usually exhibiting considerable concern. The answer to his problem is to be found in this well-organized, small volume. The authors approach the problem from an anatomical viewpoint and so miss very few, if any, causes of pain. Some are a little difficult to place in the proper compartment (or layer) and of course there is overlapping. Where one attempts to cover the ground so completely, the proper emphasis and adequate descriptions of common conditions are impossible. These are to be found in original articles and good texts, many of which are listed. References are necessary in a book of this type. These are well selected and are quite up to date. One of 1960 was noted and several as late as 1959 were included.

The book is not a bedside one or even a favorite chair companion. Style of writing cannot be very interesting where the material is so extensive. Organization is the main purpose and is well accomplished. And so for practicing physicians, it should be a good book to have around.

S. E. DOOLITTLE, M.D.

Dunham's Premature Infants, 3rd Ed.

By William A. Silverman, M.D., 578 pp., $15.00, Paul B. Hoeber, Inc., 1961.

This new edition of *Dunham's Premature Infants* as written by Dr. Silverman is a marked improvement on the previous editions. It is up to date, readable, and informative. The conciseness of the material augmented by extensive references should appeal to those who have only a passing interest as well as to those who have a much deeper interest in the problems of the premature infant.

ROSS Y. HAGINO, M.D.

★Management of Fractures, Dislocations, and Sprains

By H. Earle Conwell, M.D., and Fred C. Reynolds, M.D., 1153 pp., $27.00, The C. V. Mosby Company, 1961.

Fred C. Reynolds has assisted in the sixth revision of this classic textbook on traumatic injuries to the musculoskeletal system, this being the first revision since the death of J. Albert Key, in whose memory this edition is printed. The basic structure of the book including chapter, titles and general organization remains the same but the context has been thoroughly revised with dele-

(Continued on page 182)

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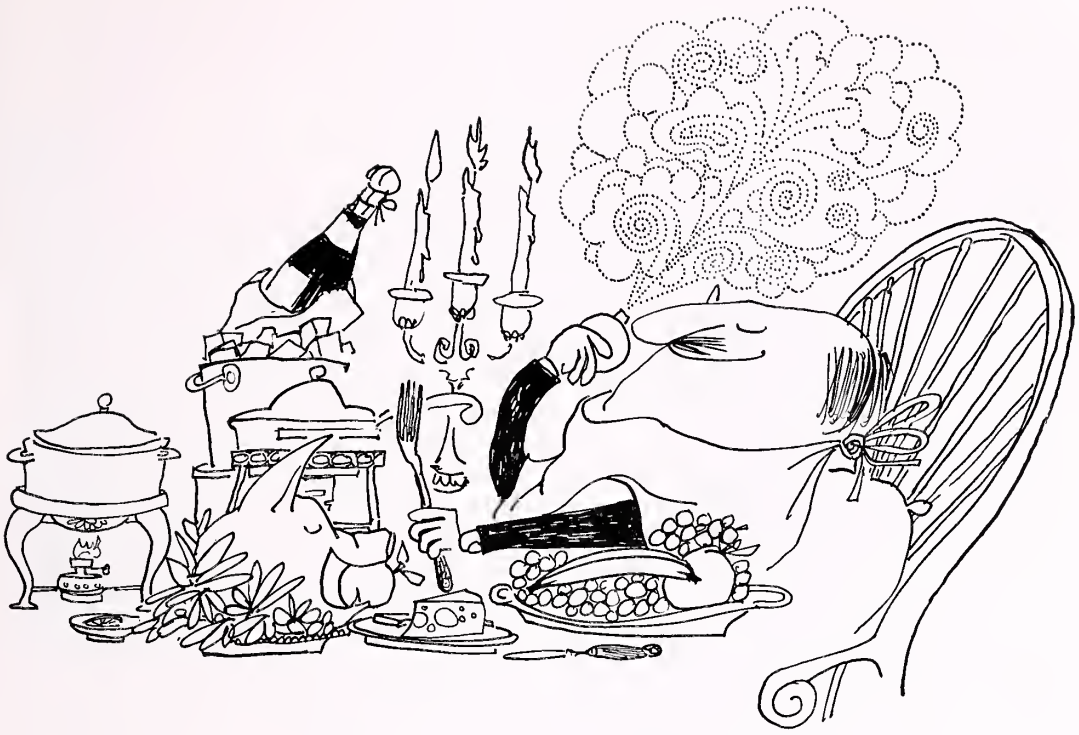
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BOOK REVIEWS

(Continued from page 180)

tion of much repetitious, obsolete material, and introduction of newer methods of intramedullary fixation and prosthetic replacement, and discussion of deceleration injuries of the cervical spine as well as intervertebral disc disease. Newer aspects of bone healing, physiology, fracture complications, and treatment, and in particular newer trends in anesthesiology with relation to the injured patient have been included in this edition, with this modernization the book remains at the top of the list of textbooks for the student of trauma-

IVAR J. LARSEN, M.D.

Also Received

The Surgical Clinics of North America, Vol. 41, No. 2

By Frank Glenn, M.D., Guest Editor, pp. 265-544, W. B. Saunders Co., April, 1961.

A symposium covering the clinical management of patients with conditions of the cardiovascular system that are benefited by surgical measures.

Somatic Treatments in Psychiatry

By Lothar B. Kalinowsky, M.D., and Paul H. Hoch, M.D., 413 pp., $9.25, Grune & Stratton, 1961.

For psychiatrists only.

(Continued on page 186)

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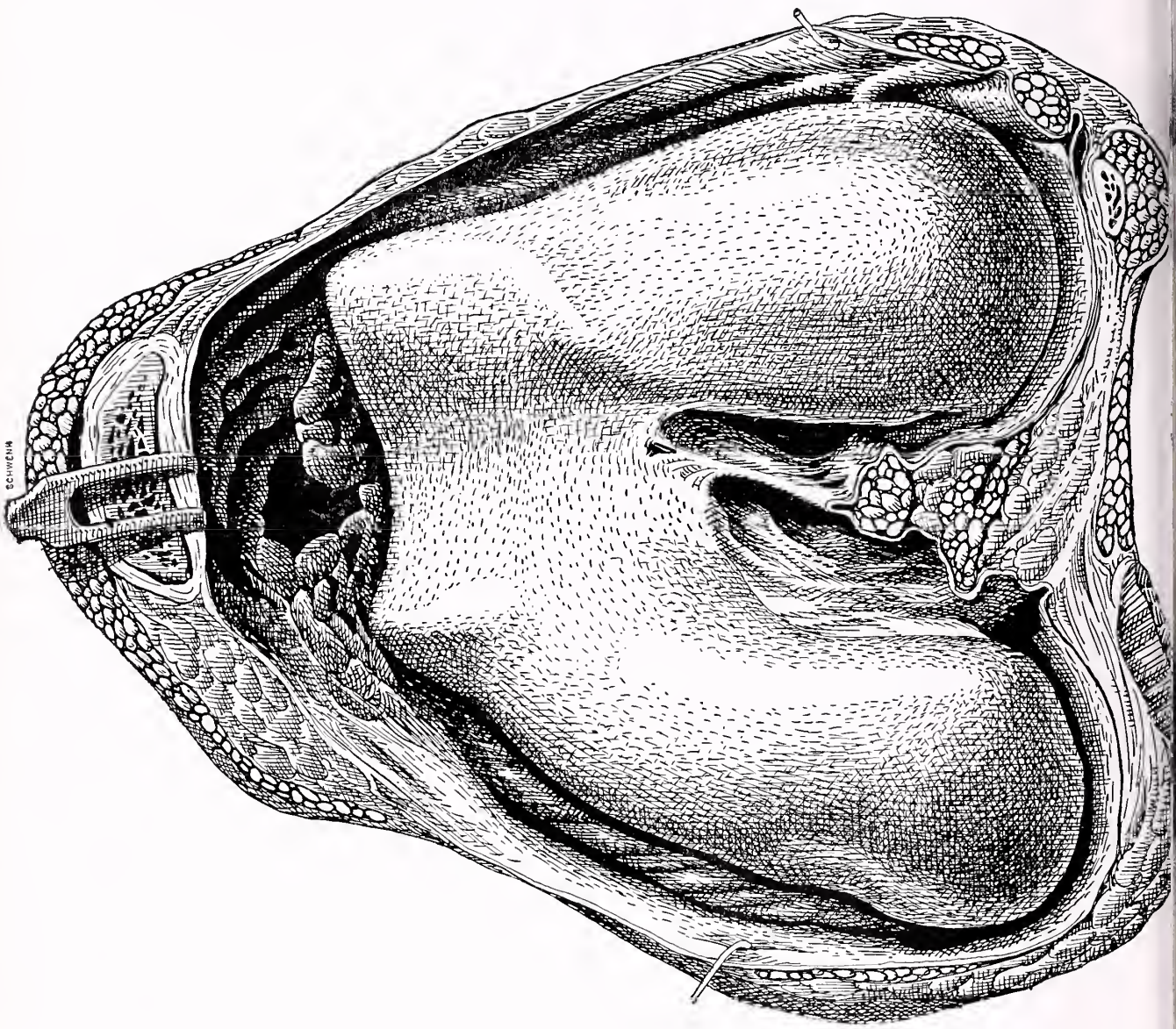
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1. Kareha, L. G., de Quevedo, N. G., Tighe, P., Kehrli, H. J., "Evaluation of Ilopan in Postoperative Abdominal Distention," Western J. Surg. Obs. & Gyn., 66:220, 1958.
2. Stone, M. L., Schlussel, S., Silberman, E., Mersheimer, W. L., "The Prophylaxis and Treatment of Postpartum and Postoperative Ileus with Pantothenyl Alcohol," Amer. J. Surgery, 97:191, 1959.

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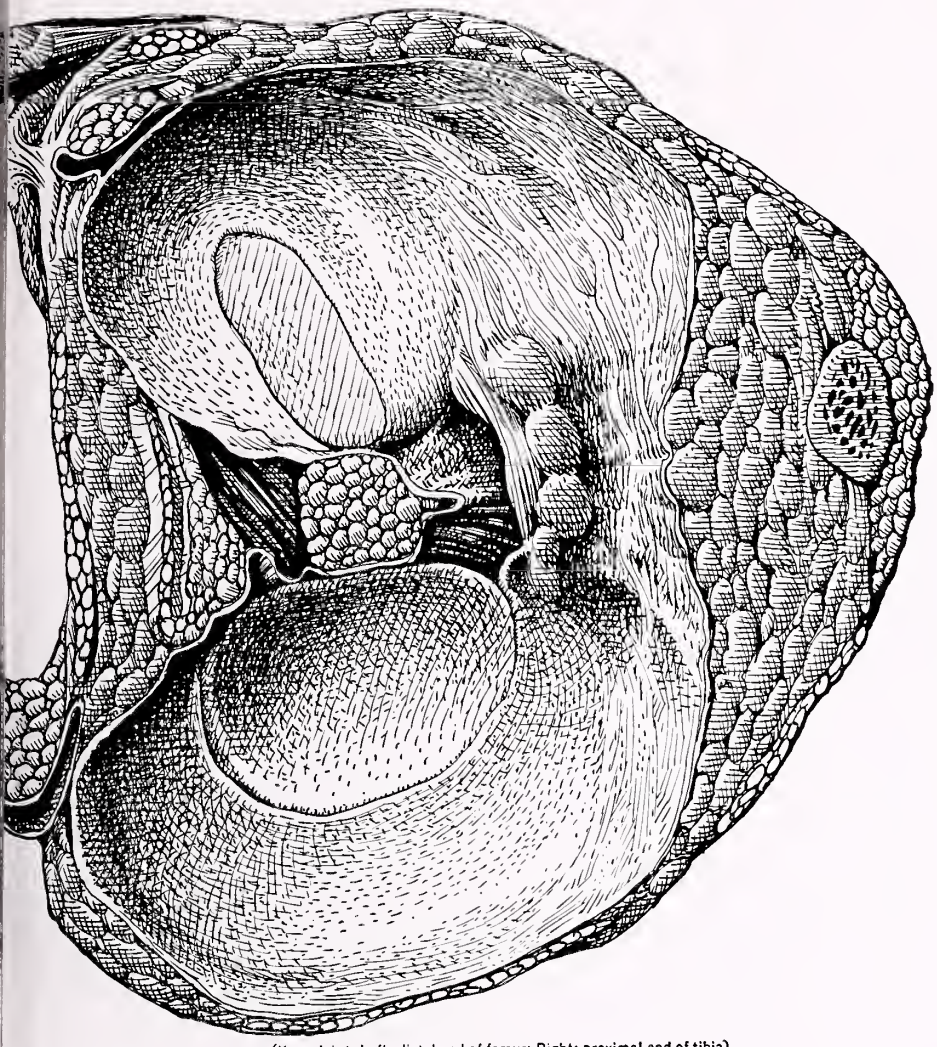
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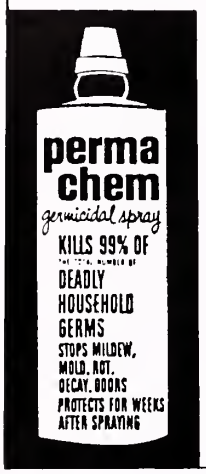
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*Journal of AMA, April 4, 1959
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(Continued from page 182)

Hypertension

Milton Mendlowitz, M.D., Editor, 156 pp., $6.50, Grune & Stratton, Inc., 1961.

Beautifully printed symposium—10 articles by 18 contributors.

Annals of the New York Academy of Sciences Vol. 91, Art. 3.

Franklin N. Furness, Editor, 223 pp., The New York Academy of Sciences, 1961.

Genetic perspectives in disease resistance and susceptibility. Wise and deep.

★Health Education

Edited by Bernice R. Moss, M.D., Warren H. Southworth, Dr. P.H., and John Lester Reichart, M.D., 429 pp., $5.00, National Education Association of the United States, 1961.

Fifth edition in 36 years of a book produced through the cooperation of the National Education Association and the A.M.A.

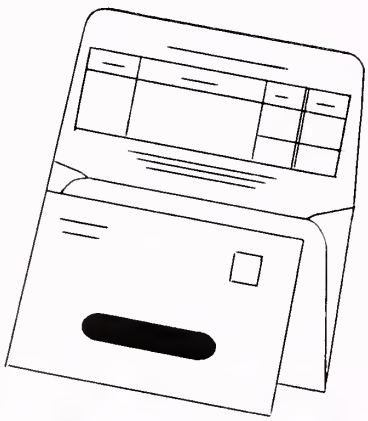
Psychology As Applied to Nursing

By Andrew McGhie, M.A., Ph.D., 267 pp., $4.50, E. & S. Livingstone Ltd., 1961.

This book is recommended to nursing instructors as well as to the student nurses for whom it was written.

(Continued on page 188)

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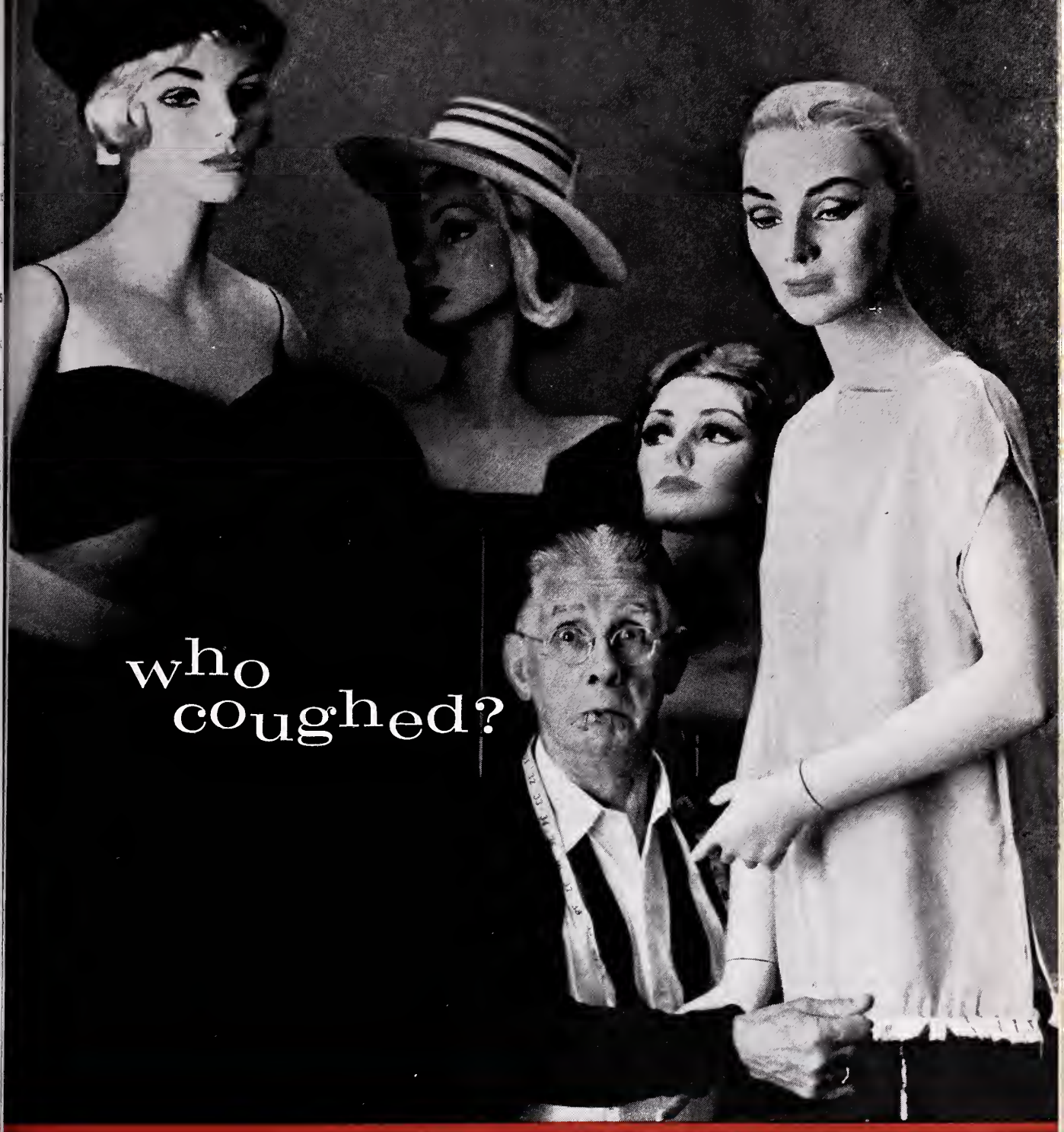


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(Continued from page 186)

Field Studies in Mental Disorders

By Joseph Zubin, Ph.D., 495 pp., $6.75, Grune & Stratton, 1961.

For investigators in psychiatry.

CIBA Foundation Symposium on Quinones in Electron Transport

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc., 453 pp., $11.00, Little, Brown & Company, 1961.

For the biochemically-oriented only.

Comparative Epidemiology of the Mental Disorders

Paul H. Hoch, M.D., and Joseph Zuzin, Ph.D., Editors, 290 pp., $9.75, Grune & Stratton, Inc., 1961.

Ecologic psychiatry.

★CIBA Foundation Study Group No. 7, Virus Meningo-Encephalitis

G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A., Editors, 120 pp., $2.50, Little, Brown and Company, 1961.

Pediatricians should own this and read it.

Multiple Sclerosis Prognosis and Treatment

By Leo Alexander, M.D., Austin W. Berkeley, Ph.D., and Alene M. Alexander, 188 pp., $7.50, Charles C. Thomas, 1961.

ACTH, if transfusions fail. There are 132 references

(Continued on page 192)

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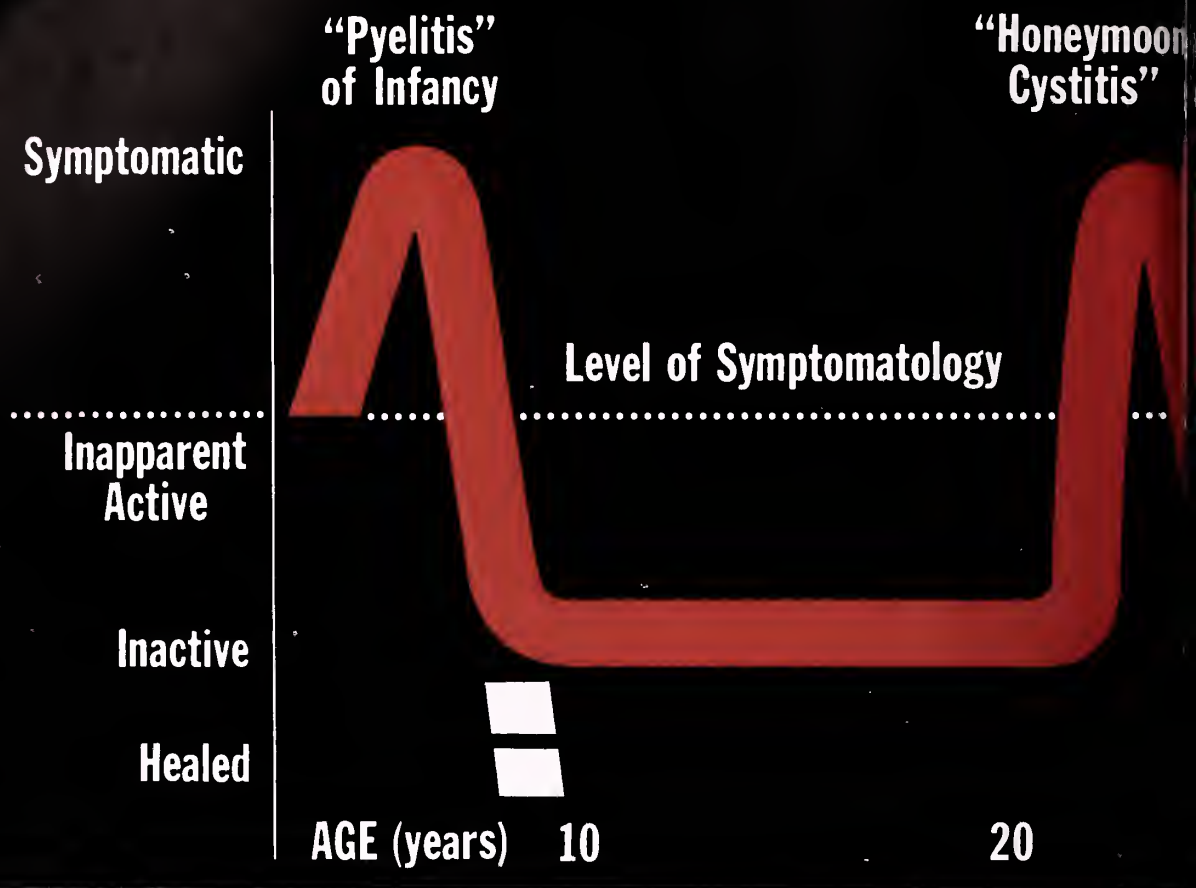
1. The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: J. Pediat. *56*:391 (Mar.) 1960.

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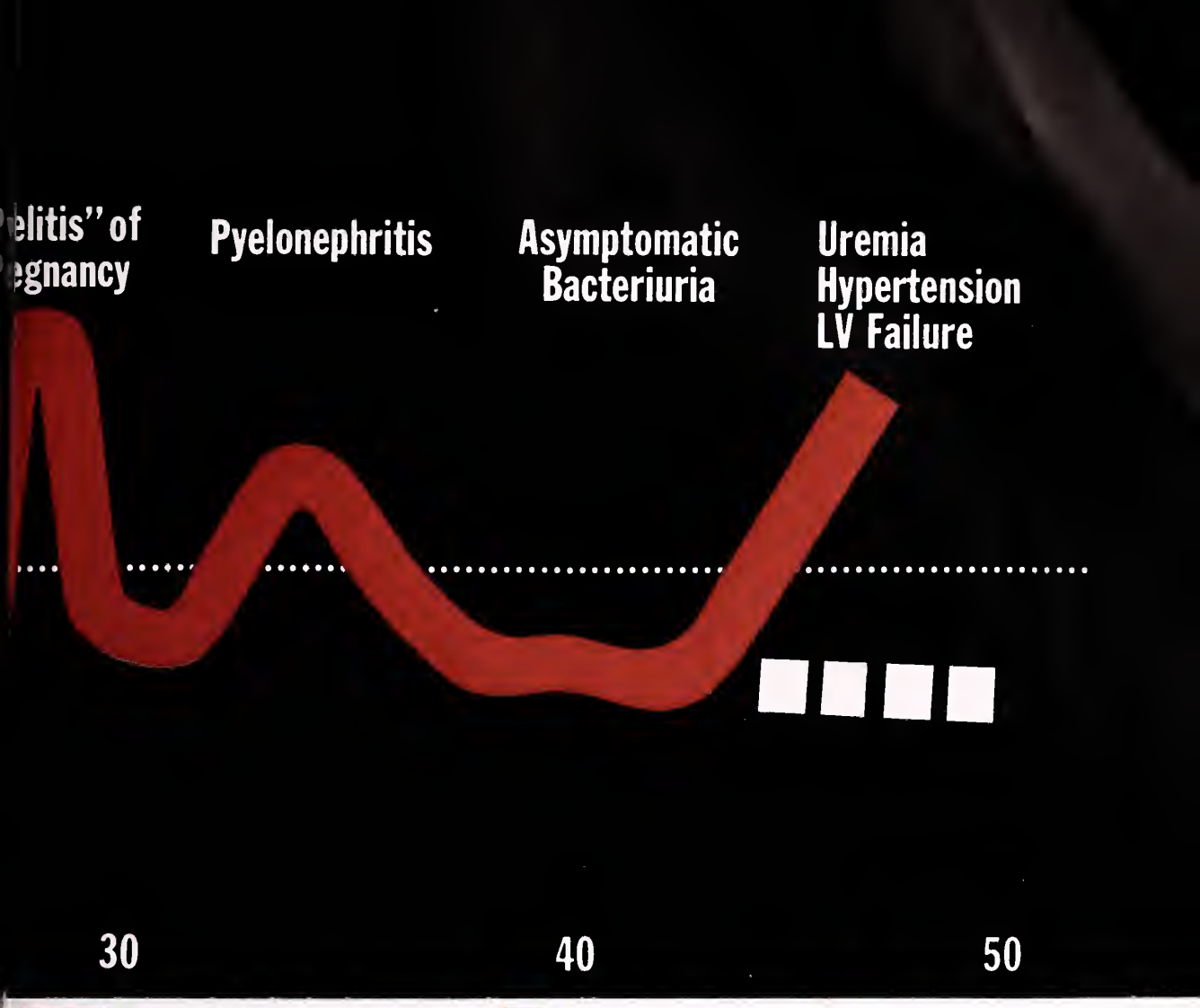
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1. Birchall, R.: Am. Practit. *11*:918, 1960. 2. Sanjurjo, L. A.: Med. Clin. N. Amer. *43*:1601, 1959.

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and a good index, a whole page of which is devoted to ACTH.

★Progress in Medical Genetics, Vol. 1

By Arthur G. Steinberg, Ph.D., Editor, 341 pp., $9.75, Grune & Stratton, 1961.

Pretty deep stuff. The essay by J. B. S. Haldane on Normal Selection in Man is worth the whole price, however. There are 404 references on hemoglobinopathies alone!

Current Psychiatric Therapies, Vol. 1

By Jules H. Masserman, M.D., Editor, 246 pp., $7.50, Grune & Stratton, 1961.

For psychiatrists. A valuable, practical symposium by 41 contributors.

The Treatment of Tropical Diseases

By W. H. Jopling, M.R.C.P., D.T.M. & H., 202 pp., $5.00, The Williams & Wilkins Company, 1960.

Very British, very brief, aimed at Africa rather than the Pacific. A useful compendium.

Vaso-Seminal Vesiculography in Hypertrophy and Carcinoma of the Prostate with Special Reference to the Ejaculatory Ducts

By Gunnar Willer Vestby, 196 pp., $7.50, Oslo University Press, 1960.

For radiologists and urologists. There are 119 clear illustrations.

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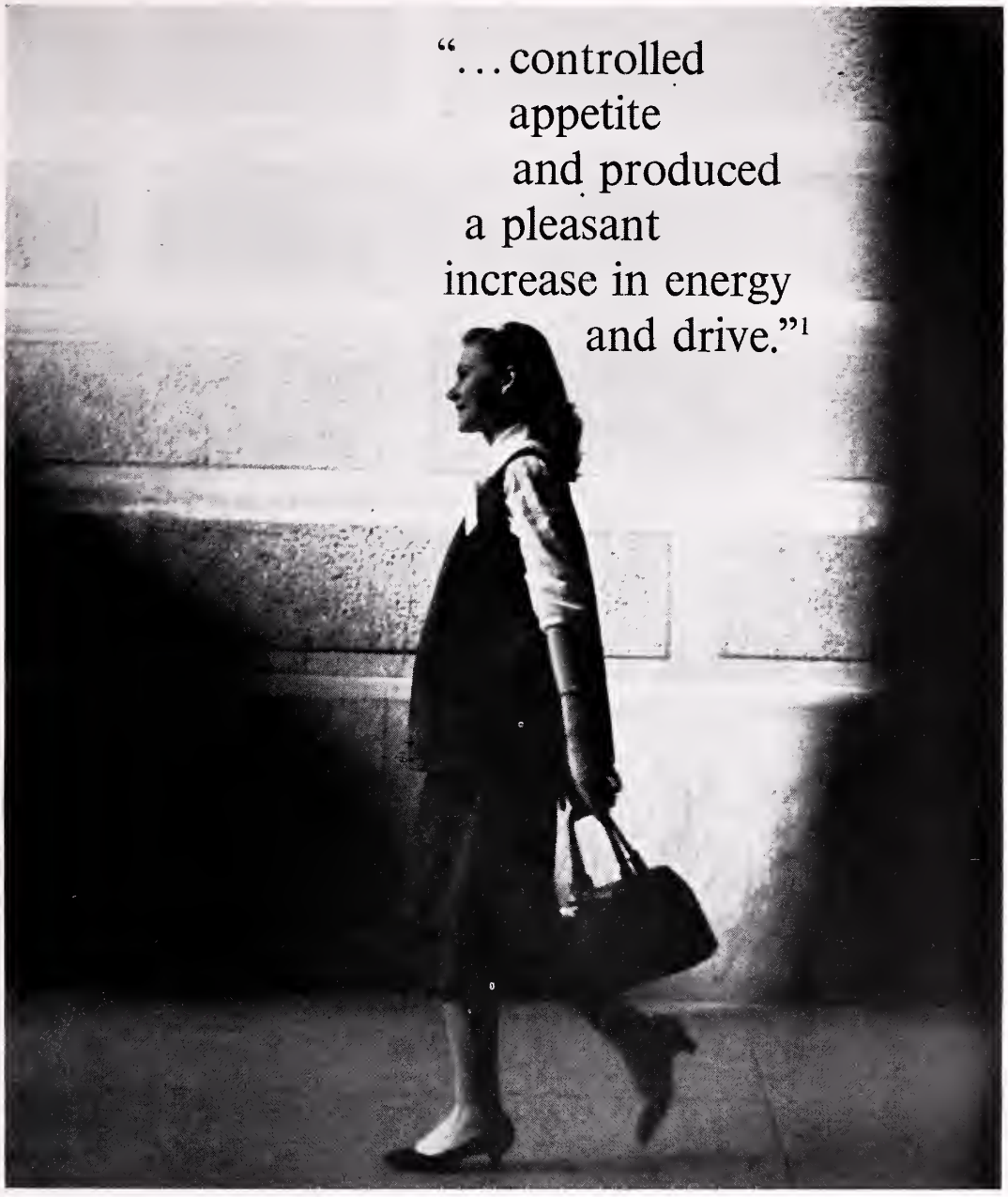
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1. Price, N.J.: The Problem of Weight Control in Pregnancy, from a report accompanying a scientific exhibit, A.M.A., Miami Beach, Fla., June 1960.

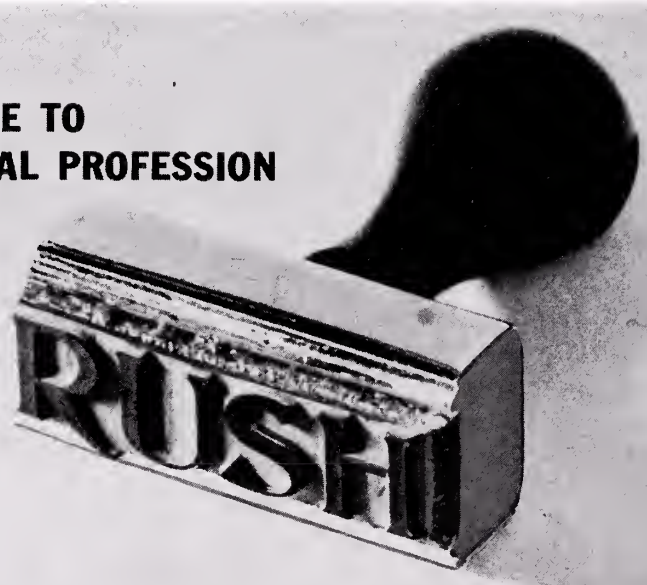
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	Page
Abbott	(Insert between pages 180 and 181)
American Factors, Ltd.	194
American Tobacco Co.	121
Ames Company	168, 195
Ayerst Laboratories	111
Baxter, Don, Inc.	175
Burroughs Wellcome	122, 163, 178, 179
Central Medical Building	188
Carnation Company	117
Coca-Cola Bottling Co.	180
Eaton Laboratories	107, 190, 191
Endo Laboratories	187
Ethicon	(Insert between pages 112 and 113)
General Electric Co.	177
Hawaii Camera	172
Hawaii Medical Service Association	150
Hawaiian Electric	166
International Travel	176
Lederle Laboratories	118, 119, 184, 185
Lilly, Eli & Co.	101, 124
Lorillard, P.	109
McKesson & Robbins, Inc.	182
Mead Johnson International	189, 196
Medical Industries	174
Medical Placement	180
Merck, Sharp & Dohme	114
O'Leary, Lydia, of Hawaii	192
Optical Dispensers	182
Pacific West Distributors, Ltd.	186
Parke, Davis Company	102, 103
Pfizer Laboratories	(Insert between pages 168 and 169)
Professional Machine Accounting, Hawaii	112
Professional Services, Inc.	169
Robins, A. H. Co., Inc.	(Insert between pages 120 and 121), 115
Ross Laboratories	167
Saunders, W. B. Co.	113
Schering Corporation	123
Schieffelin & Co.	156
Schuman Carriage	188
Searle, G. D. & Co.	157
Security Diamond Company	120
Smith, Kline & French	193
Squibb, E. R. & Sons	116, 170, 171
Star-Bulletin Printing Co., Inc.	186
Summers, Clinton D.	105
Tailby-Nason Co.	173
Universal Motors	110
Upjohn Company	108
Von Hamm-Young Co., Ltd.	192
Warren-Teed Products Co.	183
Williams Mortuary	176
Winthrop Laboratories	181

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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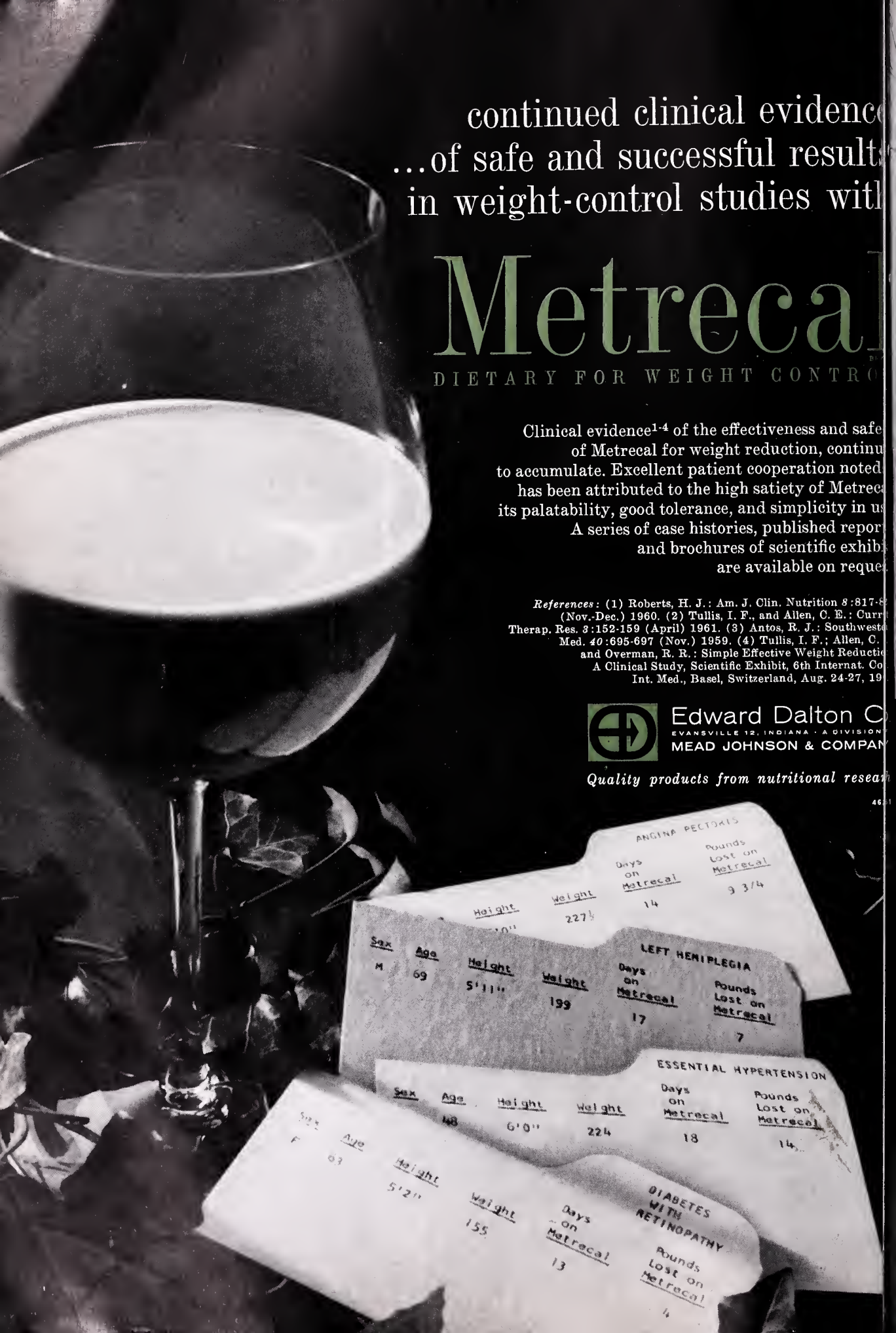
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References: (1) Roberts, H. J.: Am. J. Clin. Nutrition *8*:817-8
(Nov.-Dec.) 1960. (2) Tullis, I. F., and Allen, C. E.: Curr
Therap. Res. *3*:152-159 (April) 1961. (3) Antos, R. J.: Southwest
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A Clinical Study, Scientific Exhibit, 6th Internat. Co
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TABLE OF CONTENTS
PAGE 202

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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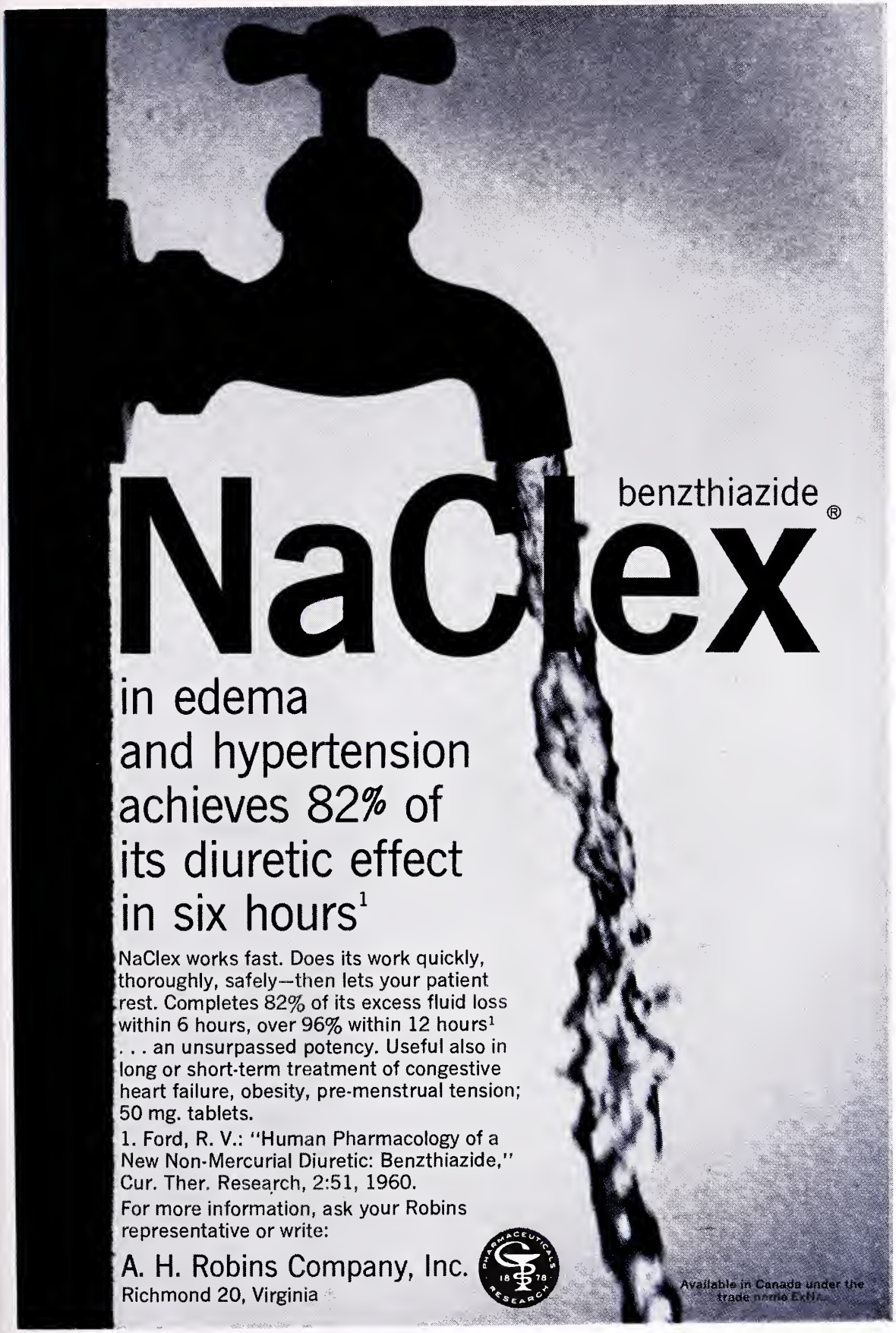
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VOLUME 21
NUMBER 3
JAN.-FEB., 1962

Contents

Scientific Articles

Recent Advances in Surgery for Deafness ..... L. Q. Pang, M.D. 221

The School Health Services Evaluation Project:
Speech and Hearing ..... Jen Fong Moo, M.D., Amy Foster, Renee Powell, Robert A. Spicer, Ph.D., and Katherine J. Edgar, M.D. 227

Trichinosis ..... Robert J. T. Joy, Capt. (MC) USA, Frank L. Miller, Lt. Col. (MC) USA, and William Dito, Capt. (MC) USA 230

Rheumatic Fever and Rheumatic Heart Disease in
University of Hawaii Freshmen ..... Thomas C. McBride, M.D. 234

Editorials

AMPAC 240
The Hawaii Birth Rate 241
Aloha, Nurses! 241

Features

Book Reviews 245
County Society Reports 246
Hawaii Medical Association 247
In Memoriam—Doctors of Hawaii—XXXVI 244
News and Views 214
Notes and News 248
President's Page 238
This is What's New! 243

Inter-Island Nurses' Bulletin

HNA Official Directory 254
General Interest 255

Hawaii Technologists' Bulletin

Observations on Staphylococcus aureus Phage-Type 80/81 Hawaii and
its Resistance to Antibiotics ..... R. H. Tanimoto, M.S. 262

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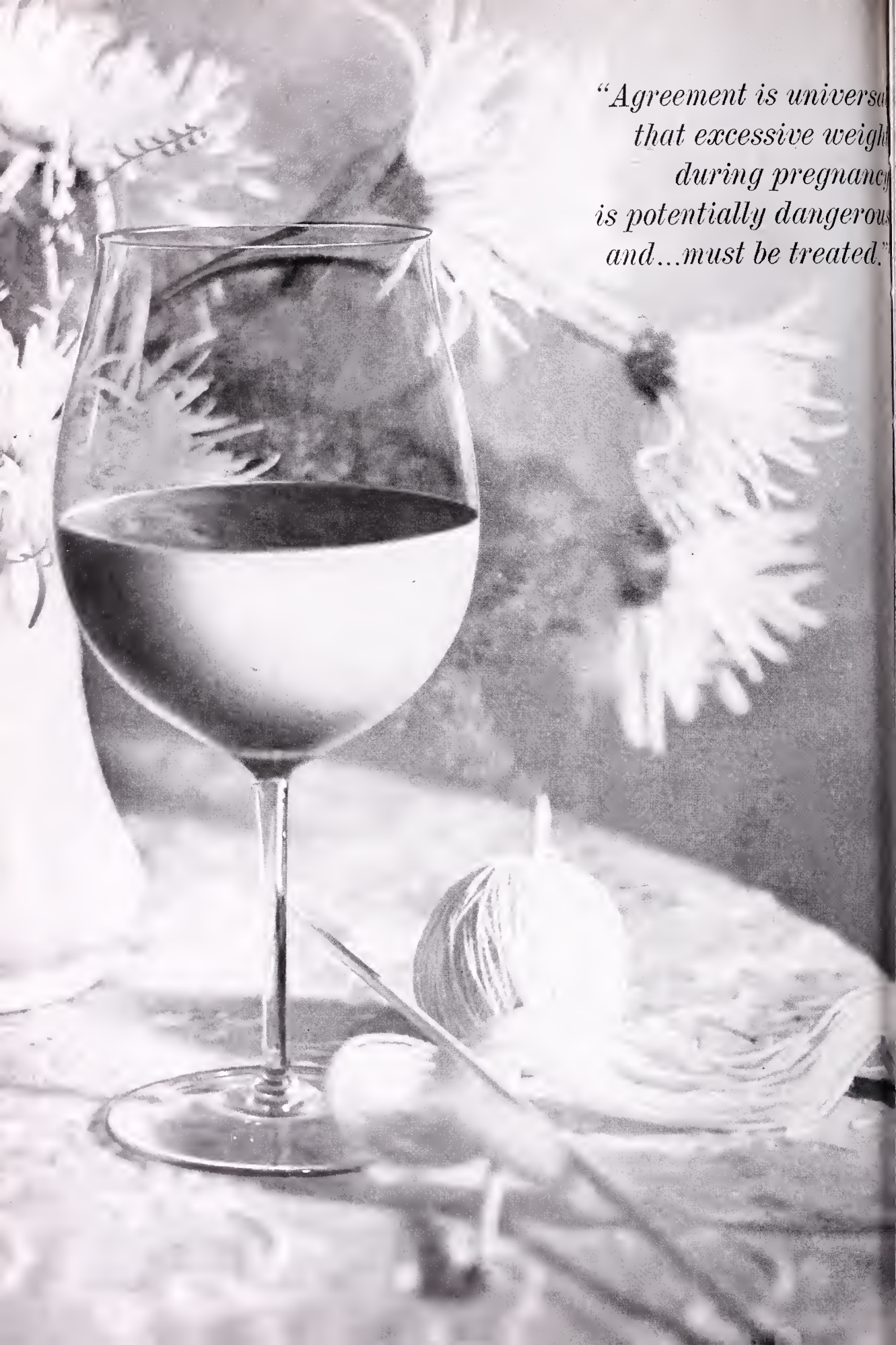
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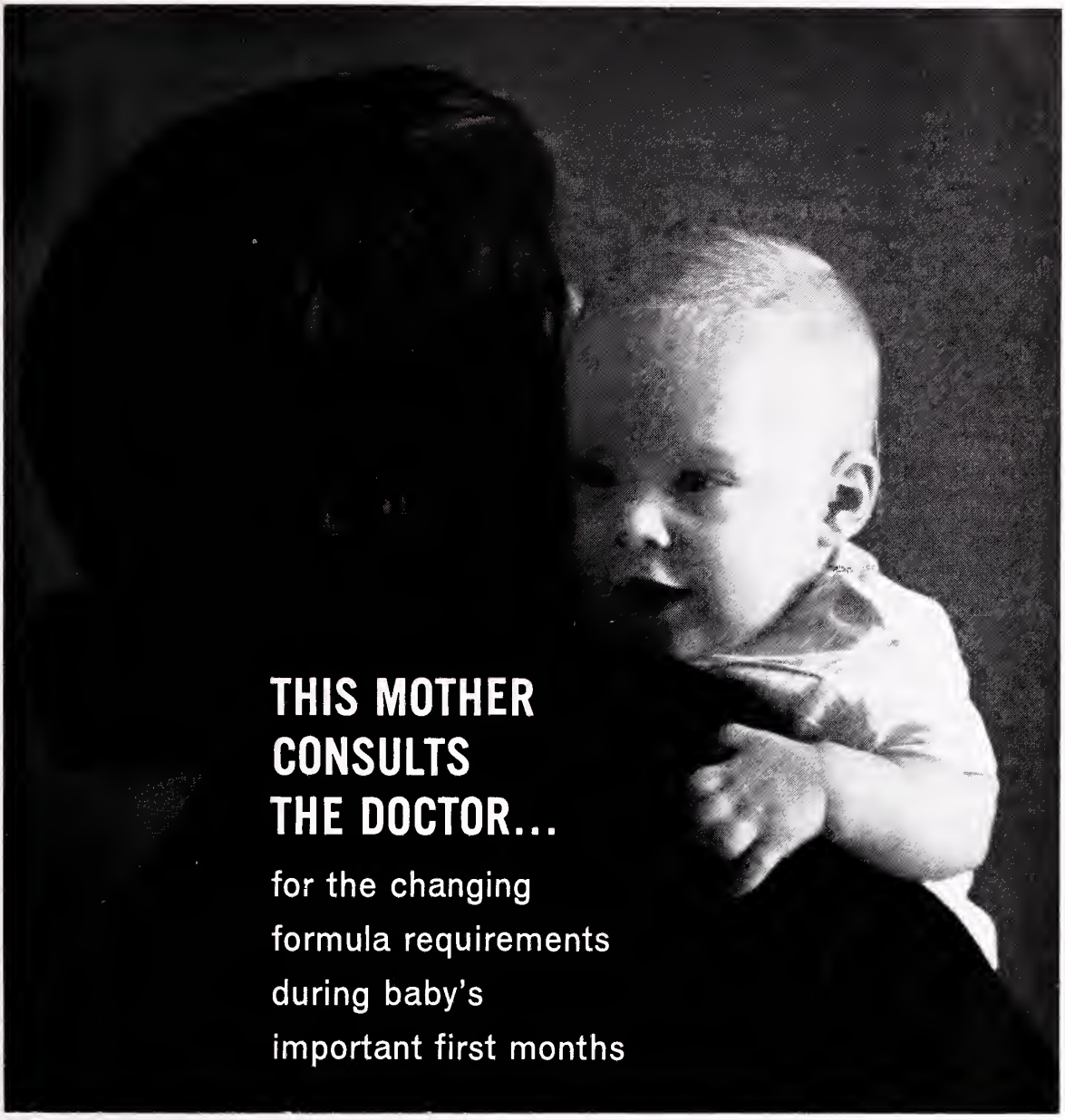
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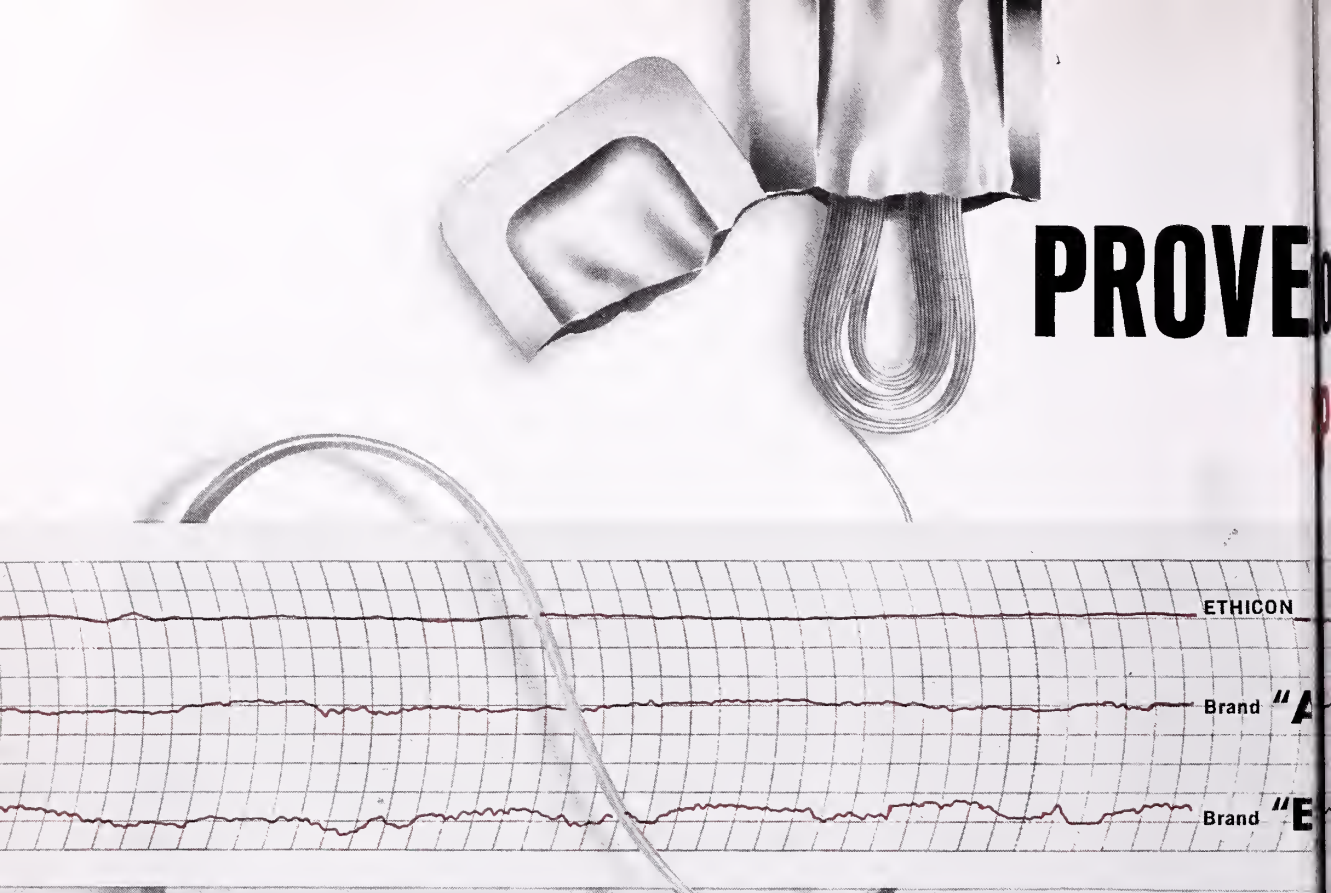
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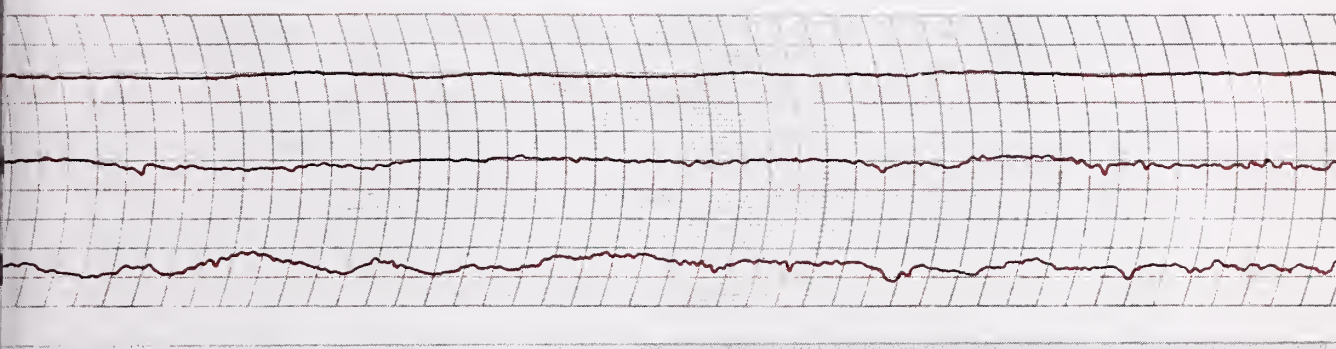
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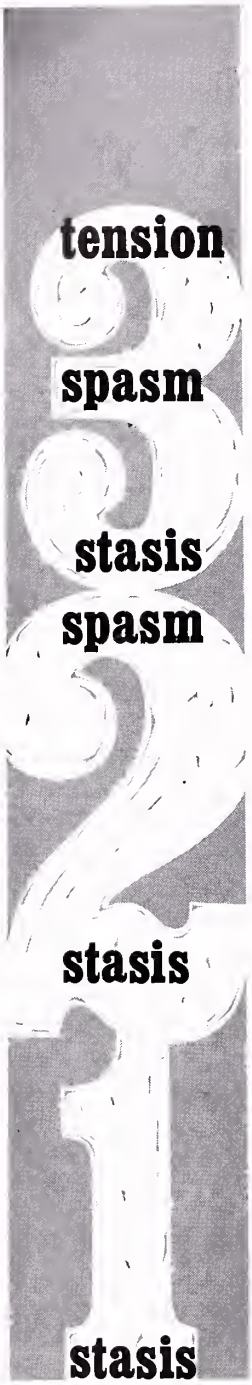
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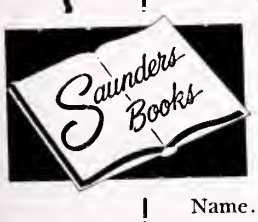
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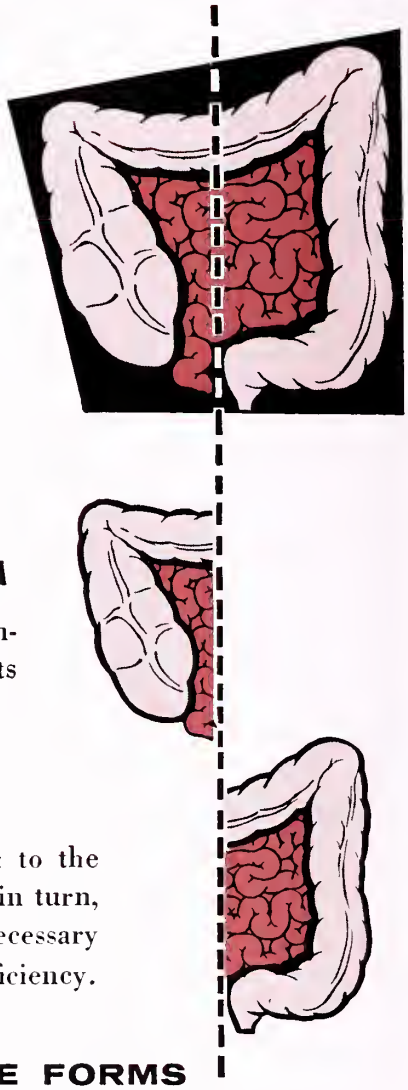
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•

A doctor was in the habit of dropping in at a certain bar every evening and ordering a Daiquiri with an almond in it. One day a substitute bartender was on duty, and in his preparations for the afternoon trade found a jar of almonds and absent-mindedly ate them all up. Shortly afterward the doctor came in and requested his usual drink. The bartender, regretting his indiscretion, slipped a hickory nut into the drink and served it. The doctor soon observed the substitution and complained that he had not been given an almond Daiquiri, as requested. "No," agreed the bartender, "you're right: that's not an almond Daiquiri. That's a hickory Daiquiri, Doc."

•

"Whom" has pretty nearly disappeared from spoken English; it is now almost as common where "who" would be correct, as where it should properly be used. Among the few who really care, there are many who don't know. Who would be stuffy enough to say "Whom did you give it to?" "Whom" is also gradually fading out of written English, and will probably have vanished completely in a few more decades. We will get along all right without it.

•

Speaking of being stuffy—it is stuffy to speak of a patient as a "male" or a "female." This doesn't sound scientific, and it isn't: it is a vague and inexact designation, equally applicable to a human, a fruit fly or a cocker spaniel. If a patient is a man or a boy, or a woman or a girl—and most of them are—then come right out and say so. It will save time, and it sounds a lot friendlier.

•

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•

Cartoon in the latest New Yorker: *man, to friend: "Be sure and give me a ring some time soon. My telephone number is 2127358962." Actually this merely prefixes the three-digit "area code" number to the seven digits already included in a number like BUtterfield 8-8962, and makes "direct dialing" possible. But it's not going to be easy to remember. The letters were better. The University of California Medical Center could be reached by dialing MOG-FOZZ.*

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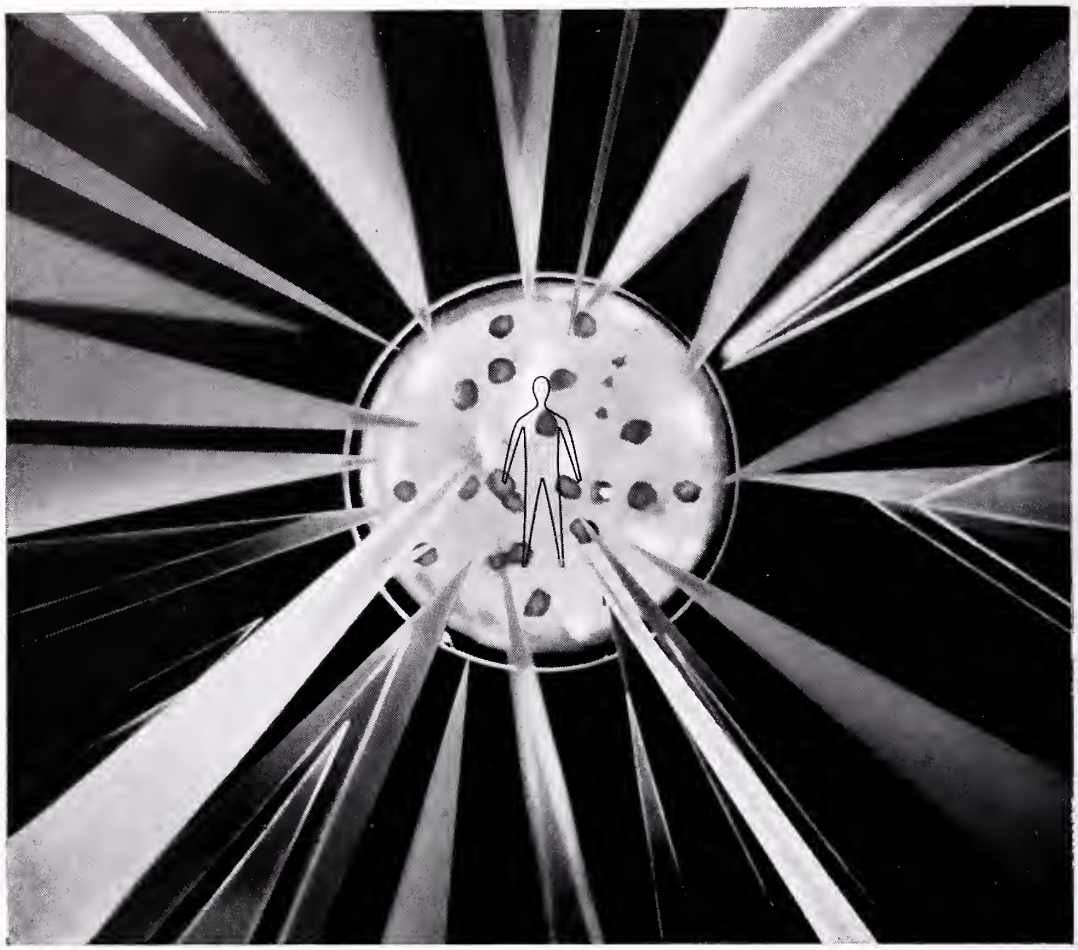
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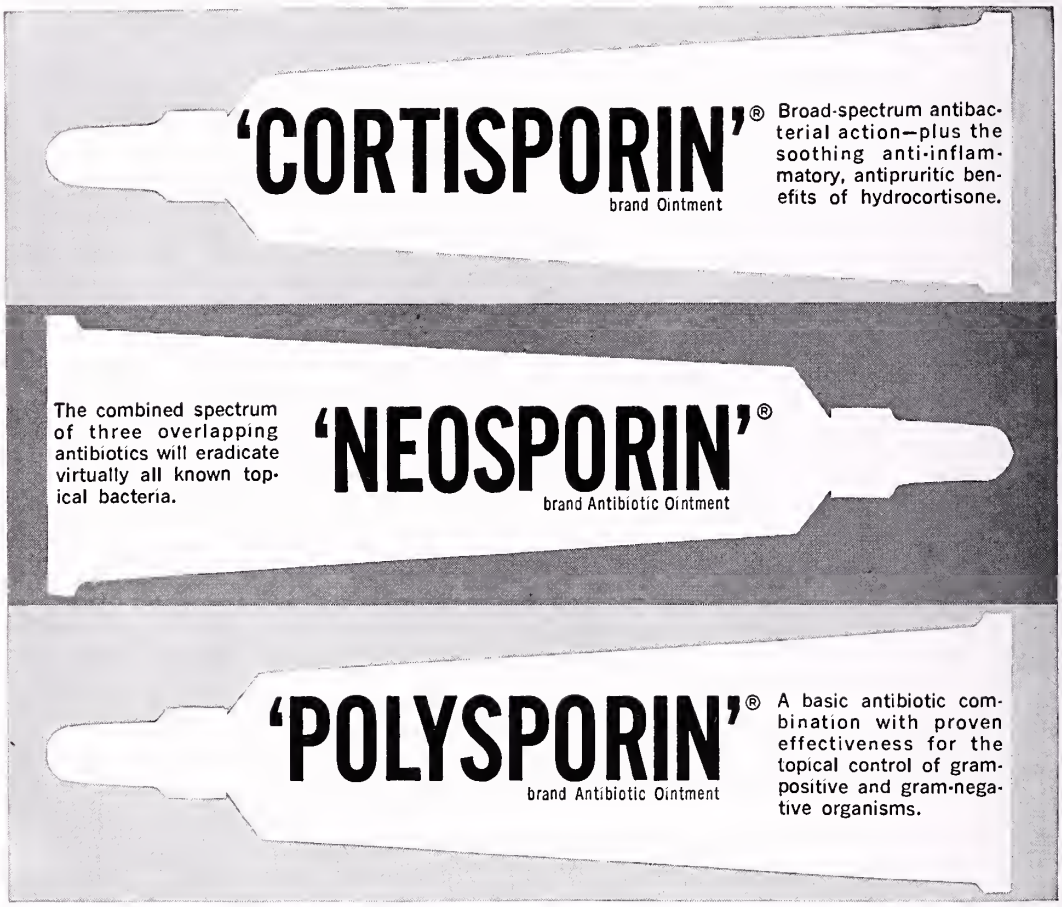
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Thursday—8:30 a.m.—grand rounds
Friday—12:30 p.m.—4th Friday of each quarter beginning in January—staff luncheon and meeting

Kapiolani

Tuesday—12:30 p.m.—weekly—didactic program and luncheon
Tuesday—4:30 p.m.—2d Tuesday of each month. Pediatric attending meeting
Tuesday—4:30 p.m.—last Tuesday of each month—ob.-gyn. statistics
Thursday—12:30 p.m.—2d Thursday of each month—Medical Executive Committee meeting and luncheon
Thursday—12:30 p.m.—3d Thursday of each month—staff meeting and luncheon
Friday—9:30 a.m.—last Friday of each month—infant mortality meeting

Kuakini

Monday—4:30 p.m.—weekly medical rounds
Tuesday—1:00 p.m.—2d Tuesday—C.P.C.
Tuesday—1:00 p.m.—3d Tuesday—medical conference
Wednesday—1:00 p.m.—alternate 2d and last Wednesday—ob.-gyn. conference
Thursday—1:00 p.m.—weekly house staff meeting and educational movies
Friday—1:00 p.m.—weekly surgical conference
Friday—5:15 p.m.—2d Friday—dinner and staff meeting

Queen's

Monday—12:30 p.m.—weekly ob.-gyn. conference
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Tuesday—4:15 p.m.—last Tuesday of each month—EENT conference
Thursday—12:15 p.m.—1st Thursday of each month—pediatric conference
Thursday—8:00 a.m.—3d Thursday of each month—psychiatric conference
Friday—12:30 p.m.—last Friday of each quarter—staff meeting and luncheon
Friday—4:15 p.m—weekly medical conference

St. Francis

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Tuesday—12:30 p.m.—4th Tuesday—medical statistical meeting
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Wednesday—12:30 p.m.—2d Wednesday—house staff meeting
Wednesday—12:30 p.m.—3d Wednesday—pediatric statistical meeting
Thursday—12:30 p.m.—1st and 3d Thursday—x-ray conference
Thursday—4:00 p.m.—weekly—surgical anatomy conference
Thursday—7:30 p.m.—3d Thursday—ob.-gyn. statistical meeting
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Modern ear surgery can do a great deal to relieve various kinds of deafness.

Recent Advances in Surgery for Deafness

L. Q. PANG, M.D.,* Honolulu, Hawaii

MODERN otologic surgery received its greatest impetus in 1938 when Lempert[1] introduced his technique for the one-stage fenestration operation for otosclerosis. His revolutionary endaural route instead of the usual postauricular incision gave a direct approach to the mastoid antrum and middle ear. His use of the dental drill and burrs replaced the chisels and gouges, and facilitated the exenteration of the mastoid cortex and cells which at times were as hard as ivory. For the first time, otologists were able to get a real look into the middle ear structures.



DR. PANG

Further impetus was provided by the introduction of antibiotics and use of the operating microscope. Antibiotics nearly eliminated operations for suppurative diseases of the mastoids and their complications. This forced otologic surgeons to turn their attention and efforts towards surgery for deafness resulting from congenital defects, otosclerosis, and the ravages of suppurative diseases. Further, it became possible for otologists to attempt various surgical procedures which had had to be abandoned by earlier surgeons because of the secondary infections. This type of surgery was also aided by the introduction into this country of the operating microscope by Shambaugh.[2]

Deafness may be due to a degeneration of the nerve of hearing, or to a failure of sound to reach the hearing nerve, or a combination of these factors. The former, or nerve deafness, cannot be corrected by any treatment or operation. The latter, or conductive deafness, can often be helped by surgery. If surgery is to be undertaken, it is necessary that the hearing nerve be sufficiently intact to be able to respond to the sound brought to it, and the eustachian tube must be open.

In each patient with a hearing loss, the possibility of help through surgery is determined by an examination of the ear, including a series of special hearing tests to determine and measure the function of the hearing nerve. From the information obtained, it is possible to predict the approximate chances for success through surgery.

In order to understand the principle of this type of surgery, some fundamental knowledge of the physiology of hearing in the normal ear is necessary.

Each sound wave consists of a compression phase followed by a rarefaction phase. These phases follow one another at a rate depending

* Read before The Hawaii Chapter of the American College of Surgeons, June 20, 1960. Received for publication February 15, 1961.

[1] Lempert, J.: Improvement of hearing in cases of otosclerosis: new one-stage surgical technique, Arch. Otolaryng. 28:42 (July) 1938.

[2] Shambaugh, G. E., Jr.: Fenestration operation for otosclerosis; experimental investigations and clinical observations, Acta Oto-laryng. Suppl. 79, 1949.

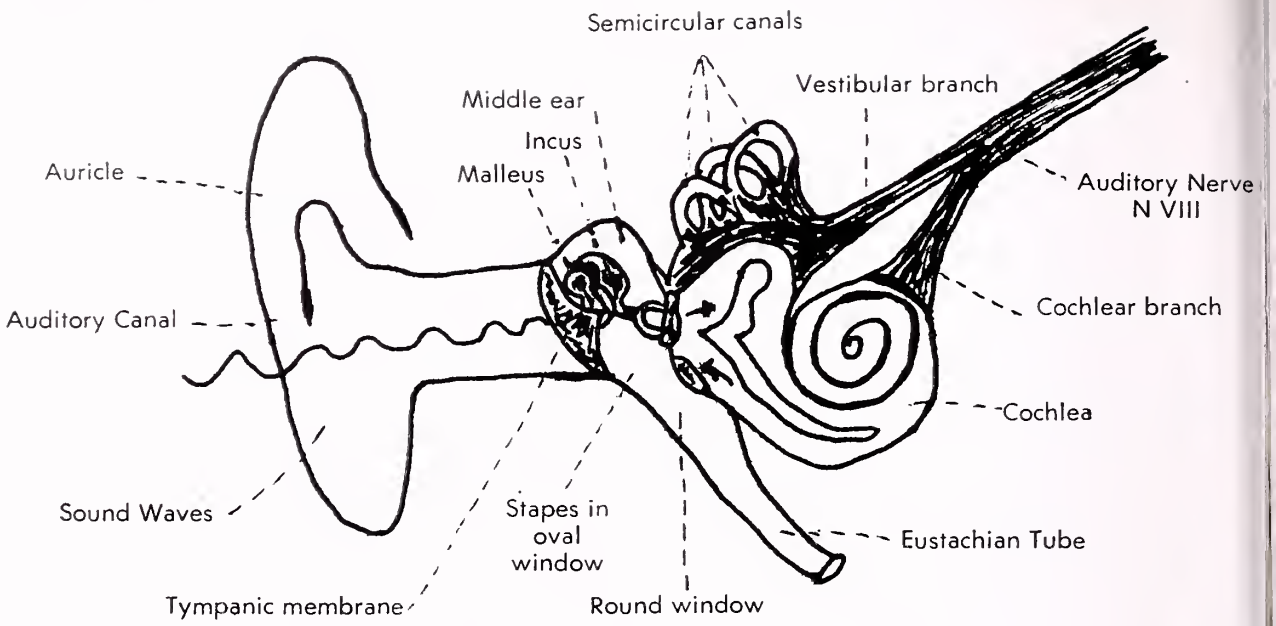


FIG. 1.—*Diagrammatic sketch of human ear showing physiology of hearing. Note that force transmitted by sound waves at the stapes is 22 times that at the round window because of the transformer ratio of the ear drum and ossicles. Round window acts as a relief opening to permit maximum movements of the perilymph. Note that the round window is medial to the oval window and that the intact ear drum shields the round window from the direct impact of sounds.*

upon the frequency of the tone. Sound waves impinge on the ear drum and set it in motion (Fig. 1). Vibrations of the ear drum are then transmitted by the ossicles to the inner ear. When the stapes moves inward, it sets into motion the intralabyrinthine fluid. This, in turn, causes a vibration of the cochlear partition where the nerve endings are stimulated to transmit the impulse to the hearing centers of the brain.

This simple explanation is sufficient for understanding the three different types of deafness. A conductive type of deafness is one caused by a failure of the sound waves to reach the cochlea and set into motion the intralabyrinthine fluid. A nerve or perceptive type of deafness is caused by a failure of the transmission of the impulses from the cochlea to the hearing centers. A mixed type of deafness is caused by a combination of the first two types.

However, this simple concept is not sufficient to explain the loss of hearing in the various pathological processes. It was only recently that otologists realized the important function of the round window. This window lies at the opposite end of the cochlear perilymph duct from the stapes footplate in the oval window, and it acts as a relief opening to permit maximum movements of the perilymph.

In the normal ear, this opening is unimportant as a competitive portal of entry of sound because (1) the transformer ratio of the tympanic membrane and ossicular chain at the stapes is 22 times the force exerted by sound at the round window, (2) the intact membrane acts to shield the round window from the direct impact of sounds, and (3) the round window is situated further medially than the oval window so that the sound waves will reach the round window a little later.

However, in a diseased middle ear, the round window may serve as a competitive portal of entry of sound because of the loss of the advantageous pressure transformer ratio (22 to 1) of the drum and ossicles, and the loss of the dampening effect of the tympanic membrane. In certain conditions, the round window may actually become the portal of entry for sound.

Surgical Correction of Congenital Defects of the Conductive Apparatus

In hearing impairment due to congenital malformations, either the sound-conduction mechanism or the sound-perception mechanism may be involved separately. This is due to different embryonic origin of the two parts of the hearing mechanism.

In a congenital defect of the sound-conduction apparatus, the pathology may consist of a microtia, an atresia of the external canal, a defect or absence of the tympanic membrane, or a defect of the os-

sicular chain. The defect may be single or multiple. Because the malleus and incus are derived from the Meckel's cartilage of the first branchial arch, which also forms the mandible, cases of involvement of these bones are often associated with a poorly developed mandible or maxilla, presenting the mandibulo-facial dysostosis known as Treacher Collins' syndrome.

Atresias may be unilateral or bilateral, the former being more common. They are more common in the male by a ratio of 2 to 1. The right ear is more often involved.

Congenital malformation of the auricle and external canal is self-evident and offers no difficulty in diagnosis. However, the presence or absence of a tympanic membrane or the condition of the ossicles cannot be determined pre-operatively. X-rays may reveal the presence of the ossicles but do not give any information as to their function. The degree of pneumatization of the mastoid cells also does not give any indication of the condition of the conductive mechanism, but does give valuable information as to difficulty one would encounter during surgery. The best indication is the stage of development of one auricle. The auricle is well formed by the third fetal month. A microtic or absent auricle would indicate an arrest in development of the branchial apparatus earlier in embryonic life and a greater malformation of the transmitting apparatus. Shambaugh[3] has found that in cases with well-formed auricles, a mobile tympanic membrane was found in over 40 per cent, and a well-formed incus and malleus in 100 per cent.

Malformation of the ossicular chain without any deformity of the auricle is not rare and is often confused with otosclerosis. However, in the presence of a history of deafness since birth and lack of progression of hearing loss, and the absence of a family history, the differentiation can be made. The definitive diagnosis is made at exploration.

There is difference of opinion as to indications for surgical correction. House[4] advises operation only in bilateral cases with good cochlear function. Shambaugh[3] feels that unilateral cases may be operated on, provided the cochlear function is sufficient to anticipate a hearing level within 20-25 decibels of the normal ear. This hearing improvement should enable the patient to have the benefit of binaural hearing and thus an improvement in ability to localize sounds and understand speech in noisy atmosphere. This pertains especially to cases where the auricle is fairly well developed.

In bilateral cases,[3] one ear may be operated on at the age of six years when an accurate gauge of hearing function can be made. Prior to this the patient may wear a hearing aid. Unilateral cases may be deferred to the age of 15-17 years, at which time the patient may want the surgery and the temporal bone will have grown sufficiently to provide better access.

Surgery for improvement of hearing in cases of atresia consists of the construction of an external canal lined by skin, and of a substitute tympanic membrane, and the management of the malformation of the ossicular chain. Since every case is different, the technique in each operation is tailored to fit the particular pathology that may be present. This is difficult surgery because the presence of severe pathology and anatomical anomalies may make it difficult to expose and identify the anatomical structures. The facial nerve frequently may be in an abnormal position, making it more vulnerable to injury.

The reconstruction of the auricle is in the realm of plastic surgery and beyond the scope of this paper. However, it is an extremely difficult and unsatisfactory procedure.

Hearing improvement depends upon the pathology present. In defects where a functioning tympanic membrane and ossicular chain is possible, the hearing may reach normal.

Closure of Perforation of the Ear Drum

Permanent central perforations of the tympanic membrane may be the result of trauma or suppurative disease of the middle ear. The histopathology of a permanent perforation is well known and has been described in a previous paper.[5]

Closure of perforation to improve hearing was started as early as 1640 when Banzer[6] recommended the use of pig bladder stretched over an ivory tube. Since then, many devices, including various sheets, membranes, and prostheses, have been used to close the perforation or to substitute for the absent drum. To date, the use of chemical cauterization (trichloracetic acid) to the rim of the perforation to promote healing and of a moist cotton patch to act as an irritant has been the most common and successful method.

The surgical repair of perforations was first described as a "myringoplasty" by Berthold[7] in 1878. However, this procedure had not received popular support until Wullstein,[8] Zollner,[9] and House[10] described their techniques.

[3] Shambaugh, G. E., Jr.: Development anomalies of the sound conducting apparatus and their surgical correction, Ann. Otol. Rhin. & Laryng. 61:873 (Sept.) 1952.

[4] House, H. P.: Management of congenital ear canal atresia, Laryngoscope 64:916 (Oct.) 1953.

[5] Pang, L. Q.: Closure of perforation of the ear drum, Hawaii Med. J. 15:122-124 (Nov.-Dec.) 1955.

[6] Banzer, M.: Dissertation on Deafness, 1640.

[7] Berthold, E.: Uber Myringoplastik, Wien Med. Bl. 1:627, 1878.

[8] Wullstein, H.: Funktionel Operationen im Mittelohr mit Hilfe des freien Spoltloppen—Transplantates, Arch. Ohren-Nasen-u. Kehlkopfh., 161:422 (Nov.) 1952.

[9] Zollner, F.: The principles of plastic surgery of the sound conducting apparatus, J. Laryng. & Otol. 69:637 (Oct.) 1955.

[10] House, H. P.: Surgical repair of the perforated ear drum, Ann. Otol. Rhin. & Laryng. 62:1072 (Dec.) 1953.

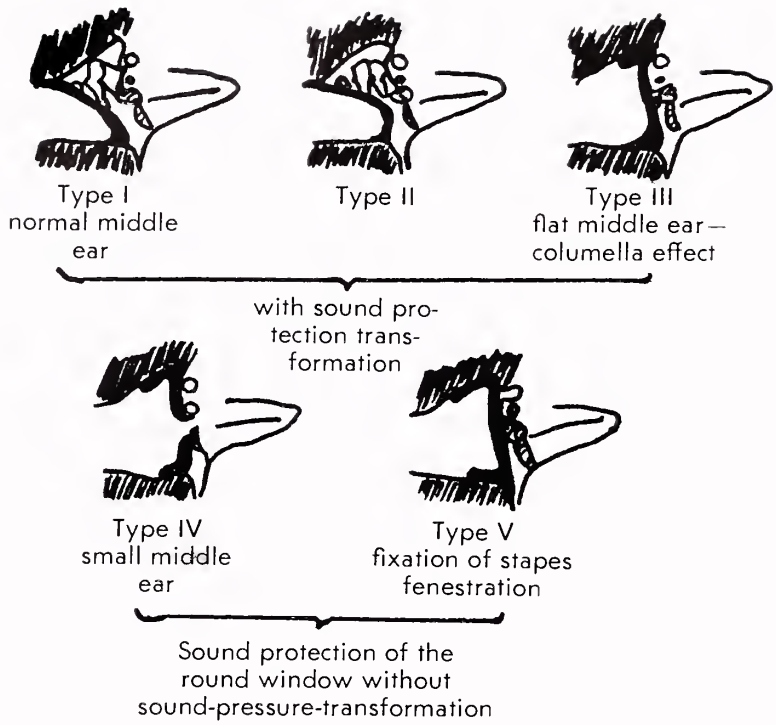


FIG. 2.—*(After Wullstein) Type I: Normal tympanic cavity. Type II: Partial defect of the ossicular chain with sound pressure transformation. Type III: Shallow tympanic cavity, columella effect. Type IV: Small tympanic cavity, sound protection of round window without sound pressure transformer. Type V: Fixation of stapes; fenestration.*

The indications for myringoplasty are the same as for closure by chemical cauterization. Myringoplasty has the advantage of being a one-stage surgical procedure. The disadvantages, however, are that successful takes occur in only about 60 per cent of cases, and that the healed membrane is not as normal in appearance or in function as the membrane following closure by cauterization. Furthermore, secondary fibrosis in the tympanic cavity may impair the mobility of the ossicles. For these reasons, myringoplasty should always be preceded by an adequate trial of acid cautery. It should be reserved for those people who have to come a long distance, or those who cannot come in for a lengthy series of weekly treatments, or in cases of an almost total central perforation with an inadequate rim of membrane for the cautery method.

The technique consists of thoroughly stripping the outer epidermal layer from the remnant of the tympanic membrane and over a zone of at least three to five mm on the adjacent meatal wall. This creates an adequate vascular bed for the graft. Adequate magnification with the operating microscope is necessary for this part of the operation. A full-thickness graft, taken from behind the ear, thinned by removal of all the loose connective tissue and fat, and then cut to the exact size, is placed against the perforation with the edges carefully everted and smoothed. Small pledgets of gelfoam and cotton balls are used to hold the graft snugly but without pressure against the vascular bed.

This surgery is done under local anesthesia in adults and under general anesthesia in children. It should not be done in the presence of a draining ear or an infection in the canal, or too soon after otitis media. Meticulous, sterile technique under magnification with the operating microscope and prophylactic antibiotic coverage are absolutely essential for the successful graft. If the graft is not successful, it should be repeated within a week or two while the vascular supply of the recipient site is still active.

More recently, Shea[11] and Tabb[12] have introduced the use of a vein graft for the closure of perforations. This consists of removing a small segment of vein from the dorsum of the hand. The vein is then split to form a sheet. The under surface of the ear drum is de-epithelialized for a distance of two to three mm from the edge of the perforation to create a raw vascular bed. The sheet of vein with the adventitial side out is then tucked in to cover the perforation from within, after the middle ear has been packed with gelfoam to serve as a support for the graft.

Tympanoplasty

Tympanoplasty is defined as a surgical reconstruction of the middle-ear hearing mechanism that has been impaired or destroyed by suppurative

[11] Shea, John J., Jr.: Vein graft closure of ear drum perforations, Northw. Med. 59:770-2 (June) 1960.
[12] Tabb, Harold G.: Closure of perforations of the tympanic membrane by vein grafts. A preliminary report of 20 cases, Laryngoscope 70:271-286 (Mar.) 1960.

disease. This term was first used by Wullstein[8] in 1953, to describe operations designed to improve hearing and eradicate disease in the various types of middle-ear suppurative disease. These operations have largely replaced the old classical radical mastoidectomy. The emphasis is on the preservation and improvement of function.

The hearing mechanism in the normal ear has already been described. However, in an ear damaged by suppurative disease, the round window may play a more prominent role in the mechanics of hearing. A perforation in the tympanic membrane removes the sound protection from the round window so that the sound waves may reach both windows at nearly the same time and cancel out the movement of the cochlear fluid.

The pathology is different in each ear. It may vary from a small to a large perforation of the tympanic membrane, defects in the ossicular chain and middle ear, and mastoid disease. It is often possible to diagnose the type of lesion preoperatively but the degree of pathology can only be diagnosed accurately at the time of surgery.

The ideal tympanoplasty consists of meticulously removing all the diseased tissue in the middle ear and mastoid, and reconstructing the middle ear to overcome the hearing defect. Wullstein has classified tympanoplasty into five basic types depending upon the degree of pathology and the resultant physiology of the reconstructed ear (Fig. 2).

Tympanoplasty is indicated to eradicate disease and improve hearing in all cases of chronic suppurative otitis media, in old radical mastoid cavities where hearing improvement is desired, in benign types of chronic otorrhea, as well as in the bone-invading type such as a cholesteatoma.

It is contraindicated in cases of a dead labyrinth or severe cochlear deterioration. It should be delayed in cases of acute labyrinthitis or intracranial complications or in an acute exacerbation of a chronic suppurative disease. The ear should be dry for a period of several weeks before surgery.

Prior to surgery, preoperative hearing tests are made to determine suitability for surgery and the probable prognosis regarding hearing improvement. The eustachian tube should be tested for patency. A paper patch test on the perforation should be done to give an indication as to whether the ossicular chain is intact or not. X-ray studies of the mastoids should be done to determine the presence of a cholesteatoma. A typical result of a tympanoplasty is shown in Fig. 3.

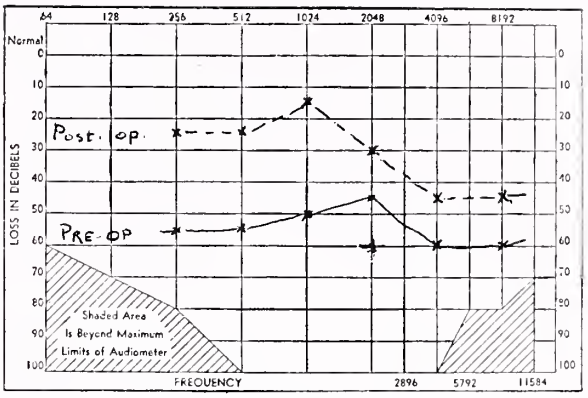


FIG. 3.—*Typical improvement in hearing acuity following Type III tympanoplasty in a 50-year-old man.*

Otosclerosis

Otosclerosis is the most important cause of a progressive conductive deafness in adults. It affects about 0.5-1.0 per cent of Caucasian adults. It is more prevalent in women. This progressive deafness usually starts at the age of puberty, is aggravated by pregnancy and lactation. There is a strong familial tendency. It is rare in Negroes. It is supposed to be rare in the Japanese and Chinese but I do not think that this is true. While I do not have figures, it is my impression that it is not rare in the Orientals but occurs less frequently than in the Caucasian.

In this disease there is a normal ear drum and a normally functioning patent eustachian tube. The pathology consists of a localized form of irregularly arranged new bone occurring most often in the area of the labyrinthine capsule, just in front of and in the region of the oval window so that there is a gradual fixation of the stapes. In the great majority, the pathology is located in the anterior crus of the stapes. Occasionally, the pathology may be localized in the round window.

The diagnosis is made by a history of a gradually progressive hearing loss, the presence of a normal ear drum and normally functioning eustachian tube, and a typical audiogram.

The one-stage fenestration was first perfected by Julius Lempert[1] in 1938. It is successful in giving practical hearing in 80 per cent of the ideal and suitable cases. The closure of the fistula has been gradually cut down to five per cent or less.

The disadvantages of the operation are that (1) it is a major operation, (2) the hearing never returns to normal, (3) the cavity needs frequent cleansing, (4) there often are severe labyrinthine symptoms following surgery, (5) the patient can never swim, and (6) it cannot be done in unilateral cases.

The stapes mobilization has largely replaced the fenestration operation for otosclerosis. The difference between these two operations may be illustrated by comparing the problem to a road blocked by huge rocks: a detour may be made or the obstruction may be removed. The fenestration is a

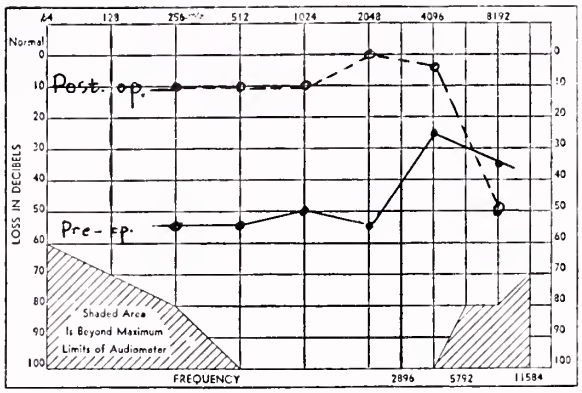


FIG. 4.—*Improvement in audiometric tracing following stapes mobilization in a 53-year-old woman.*

detour operation while the stapes mobilization removes the block. The earliest attempt at stapes mobilization was in 1878 by Kissel.[13] However, this operation gradually fell into disrepute until it was recently revived by Rosen[14] in 1953. Rosen accidentally mobilized the stapes while palpating it in a case he was fenestrating. The improvement of hearing was immediate and sensational. Rosen's method consisted of mobilizing the stapes by the indirect approach through the head and neck of the stapes. However, this often resulted in a fracture of the crus of the stapes. Also, in many cases that were mobilized, a refixation of the stapes occurred. Because of this, new methods were introduced. The trend now is to attack the lesion directly at the footplate with chisels and picks, etc.

Shea[15] in 1958, presented a different and more logical approach in the cases that could not be mobilized by the usual methods. This consisted of removing the stapedial head and crura, as well as part or all of the footplate, and then covering the opening into the vestibule by a vein graft taken from the back of the patient's hand. A polyethylene tube is then fitted to the lenticular process of the incus with the medially pointed extremity resting on the vein graft. This re-establishes the normal hearing mechanism. More recently, Schuknecht[16] and Kos[17] have used fatty tissue and a vein plug to cover the fenestra. These are connected to the incus by means of stainless steel or tantalum wire. These methods have succeeded in improving the hearing in 80 per cent of the cases (Fig. 4).

The advantages of the stapes mobilization are (1) it can be done under local anesthesia; (2) hospitalization is a minimum, usually two days; (3) there is little or no vestibular reaction; (4) it can be done in cases which are not suitable for a fenestration; (5) it can be done in unilateral cases; (6) the hearing may be restored completely to normal.

Summary

A fundamental discussion of the physiology of normal hearing is presented, sufficient to bring about understanding of the three main types of deafness, but not sufficient to explain the loss of hearing in the various pathological processes.

The role of the round window in pathological processes of the middle ear is explained.

A brief discussion of the various types of surgery for the improvement of hearing in middle-ear deafness is presented.

[13] Kissel, J.: Uber das Mobilisieren des Steigbrigels durch Ausschneider des Trommelfelles, Hammers and Amboss bei der Tuba, Arch Ohrenk., 13:69, 1878.

[14] Rosen, S.: Mobilization of the stapes to restore hearing in otosclerosis, New York J. Med. 53:2650 (Nov. 15) 1953.

[15] Shea, J. J., Jr.: Fenestration of the oval window, Ann. Otol. Rhin. & Laryng. 67:932 (Dec.) 1958.

[16] Schuknecht, H. F., McGee, T. M., and Colman, B. H.: Stapedectomy, Ann. Otol. Rhin. & Laryng. 69:597 (June) 1960.

[17] Kos, C. M.: Vein plug stapedioplasty for hearing impairment due to otosclerosis, Ann. Otol. Rhino. & Laryng. 69:559 (June) 1960.

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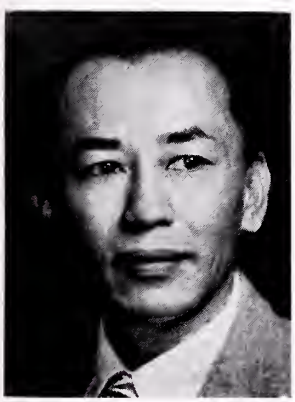
1962 Fund Drive

Don't neglect audiometry for children who seem to have a slight loss of hearing. It may be important.

The School Health Services Evaluation Project: Speech and Hearing

JEN FONG MOO, M.D., MRS. AMY FOSTER,* MRS. RENEE POWELL, ROBERT A. SPICER, Ph.D., and KATHERINE J. EDGAR, M.D., Honolulu

SHOULD a doctor be concerned with referrals of school children having minor hearing losses? Is a school program of detection and referral for hearing loss adequate if it is limited to second graders? Would rescreening in higher grades reveal many new and unknown cases? These were some of the questions which the Oahu Fifth-Grade Hearing Survey attempted to answer in 1957-58.



DR. MOO

Today, most recent studies by the American Academy of Ophthalmology and Otolaryngology committee on health aspects of hearing conservation[1] reveal that these same local questions are of national concern. Over twenty years of experience in testing hearing have brought us closer to an understanding, but have not solved all problems.

However, simplified testing techniques and national standardization of testing techniques and terminologies may some day point the way to an annual universal hearing-testing program of all school children.

The question is no longer whether there should be a hearing-testing program in the schools. The cold-blooded fact is that undetected losses of hearing are costly in terms of repeated years in the classroom,[2] and the even greater cost of vocational rehabilitation of adults whose hearing handicaps are often needlessly greater than they might have been if earlier detection (followed by medical care), had been available. There is still no valid method of case finding other than the audiometer in skilled hands, and no less expensive way of case finding exists. According to one authority,[3] "It must be remembered that a hearing impairment is an unseen defect and frequently impossible to detect by the individual himself, much less by an observer." This "unseen" defect is something which the schools cannot afford to ignore and which the taxpayer cannot afford to neglect.

A generation ago Dr. Horace Newhart outlined the educational and medical objectives of the school program of hearing-testing as follows:[4]

1. To provide that the child with defective hearing will receive special education care;
2. To make possible early application of medical or surgical corrective treatment;
3. To safeguard the child against the possible burden of a severely handicapping loss of hearing in later life from causes which are known in many cases to have their origin in pathological conditions present in childhood.

Today we would probably want to add a fourth objective of parental guidance for the families of young children, and realistic vocational guidance for hearing-handicapped students in the secondary schools.[5]

In the year 1957-58, when this study was initiated, the Department of Public Instruction was undertaking the testing of the second grade only[6]

* Supervisor, Speech and Hearing Program, DPI.

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[1] Proceedings of working conference, 1959, supplement to Transactions of American Academy of Ophthalmology and Otolaryngology (Nov.-Dec.) 1959.

[2] Irwin, R. B.: Speech and hearing therapy, Englewoods, N. J., Prentice-Hall, Inc., 1953, p. 36.

[3] Dahl, L. A.: Public school audiometry: Principles and methods, Danville, Ill., The Interstate Printers and Publishers, 1949, p. 47.

[4] Newhart, H.: The early detection and treatment of defective hearing in children, J.A.M.A. 109:1620-23 (Nov. 13) 1937.

[5] Pastore, P. N. (Chairman of Committee): Early case finding (detection), health aspects of hearing conservation, Amer. Academy of Ophthalmology and Otolaryngology (Nov.-Dec.), p. 38, 1959.

[6] The case finding method preceding 1954 in Hawaii consisted of screen-testing by Massachusetts Phonograph Test, followed by re-test by pure-tone audiometer. In 1954, Drs. Carhart and Kinney on a visit to Hawaii, recommended a change over to a minimal early-grade testing for all children on a pure-tone audiometer. The second grade was selected as a beginning, minimal program.

and retesting failure from previous years along with new referrals from teachers. Medically significant losses among this age group averaged about five per cent. The vast majority of these children had no previous history of medical consultation or treatment for hearing loss. Comparison of statistics with other state or city programs was and is difficult, due to national lack of standardization in testing techniques and criteria. Wide ranges in survey results varied from a reported five per cent of a large sampling of young school children in Ohio to 10.6 per cent of 962 children in grades six, seven, and eight in the Toronto public schools.

The Wisconsin State Fair Survey[7] revealed that 16 per cent of the participants, from all age groups, showed significant hearing losses. In the absence of comparable local statistical information, the first step toward ascertaining the values of rescreening at older ages in schools in Hawaii was made in the fifth-grade project in 1957-58.[8] As a result of this study and the national trend toward expansion of hearing-conservation programs, by 1960 the DPI testing had increased to include, whenever possible, the kindergarten (for earliest possible detection of losses), the second grade, the fifth and seventh grades, and the tenth grade (in order to have up-to-date information necessary for the vocational counselling of students).

Simplified transistorized screen-testing audiometers have made it possible to double the coverage in recent years without additional staff. In the future it is hoped that with the aid of even more easily operated equipment, universal annual testing of school children may become practical. The use of simplified audiometers in the hands of the volunteer or teacher saves the time of the highly trained audiometrist or audiologist for those children who have failed the first screening. It may soon be possible to reduce the expense per child to an amount so small that we will find we cannot afford not to test every child every year, much as vision is tested in Hawaii.

Findings of Survey

Beginning in September, 1957, and extending through the 1957-58 school year, the School Health Services Evaluation Project (sponsored by the Oahu Tuberculosis and Health Association) examined a sample of 1,065 children on Oahu.[8] The random sample included approximately 14 per cent of fifth-graders on this island. Each child received an audiometric sweep check in both ears.[9] When a significant hearing loss was found,[10] a pure tone threshold audiogram, including bone conduction[11] was done. Findings were recorded on a four-point scale as:

		NUMBER OF STUDENTS
Category I:	Not remarkable—children with normal hearing and those with a loss in one frequency in one ear	969
Category II:	Potential handicap—children with a hearing loss greater than 20 db. in two or more frequencies (500, 1000, 2000, 4000, and 6000 cycles) in one or both ears but not seriously involving the speech range	89
Category III:	Health and adjustment handicap—children with an average loss in the speech range (500, 1000, and 2000 cycles) which exceeds 20 db. in the better ear	6
Category IV:	Incompletely diagnosed—questionable responses to testing	1
	Total	1,065

The findings indicate that of the 1,065 children evaluated, 95 (9 per cent) showed a significant loss of hearing. Henceforth in referring to the degree of hearing involvement, the term Category (I, II, III, IV) will be used rather than the descriptive definition.

In order to determine whether parents of the 95 children in Categories II and III were aware of their children's hearing loss, parents were interviewed by a social worker following the examinations. The information was recorded and an evaluation of the data indicated that, as would be expected, 71 per cent of the hearing losses were known to neither school nor parents. Two per cent of the children with hearing losses were known to the parents only. The balance were known to both the school and the parents.

No single racial group had an unusually high incidence of hearing loss.

RACE	PER CENT DEFECTIVE HEARING	PER CENT GENERAL POPULATION
Japanese	34%	35%
Chinese	5	6
Filipino	12	12
Caucasian	15	23
Hawaiian or Part-Hawaiian	18	19
Other	15	5
Total	99%	100%

Regarding the six children in Category III, the otologist found that three had conductive losses,

[7] Glorig, A.: Hearing conservation, past and future, health aspects of hearing conservation, Amer. Academy of Ophthalmology and Otolaryngology (Nov.-Dec.) 1959, p. 24.

[8] See Preliminary Report in HAWAII MED. J., 19:299-304 (Jan.-Feb.) 1960.

[9] A sweep check differs from a threshold audiogram in that a sweep check is done at constant intensity level. For this study 500, 1000, 2000, 4000, and 6000 cycles were screened with the sweep check method at an intensity of 20 db. using a Maico audiometer.

[10] Significant hearing loss: a loss greater than 20 db. in two or more frequencies in one or both ears for the following: 500, 1000, 2000, 4000, 6000 cycles.

[11] A threshold audiogram is a graphic summary of the measurement of hearing loss showing number of decibels lost at each frequency tested. In this study, threshold audiograms included 250, 500, 1000, 2000, 4000, 6000, and 8000 cycles by air conduction and 250, 500, 1000, 2000, 4000 cycles by bone conduction.

one a perceptive loss, and two mixed losses.[12] Of the three children with conductive losses, two had active secretory otitis media. In one case both parents and school were unaware of the condition. In the second case the otitis media was known to the parents but they failed to seek medical care; the survey records indicate that this was a neglected child in other ways. The third child with a conductive hearing loss had received medical treatment, and the examining otologist felt that he had an irreversible conductive loss which was fairly static. Otologic findings were not remarkable in the one child with the perceptive loss; the hearing loss was known to both the home and the school. The last two cases were diagnosed as mixed losses. The otologist found that enlarged tonsils and adenoids were contributing to the defective hearing of one child and that the other had a perforated eardrum. Medical treatment was recommended for both children. The hearing loss in one child was not known to the school or parents; however, the parents and the school separately were aware of defective speech which was found to be related to the loss of hearing.

Otologic examinations were not limited to children with hearing losses. All of the children in the study group were examined by the otologist. Of the 969 children with normal hearing (Category I), 58 (six per cent) were found to have otologic conditions. Otitis media was present in 17; two had hypertrophied tonsils and adenoids; 21 were found to have allergic rhinitis; and 19, chronic sinusitis.[13] Some children had two or more of the above findings. None of these children had hearing loss as measured the day of the examination.

Of the 95 children with hearing losses (Category II, III), only three had evidence of allergic rhinitis and two had chronic sinusitis, whereas 40 had hypertrophied tonsils and adenoids and 34 had evidence of otitis media. It will be noted that most of the children who were found to have allergic rhinitis had normal hearing, and that very few of the cases of conductive hearing loss had associated allergic rhinitis.

Each child participating in the study was also given a brief speech evaluation. If no abnormal rhythm patterns were noted, if the voice quality was not unusual, and if sound substitutions and omissions were limited to those errors typical of island speech, the speech was recorded as "not remarkable." If the speech was found to be truly defective, classification was made as to type and severity. A condition was recorded as minor if it was a socially acceptable speech pattern, and a health and adjustment handicap if it attracted unfavorable attention to the speaker, or if it interfered with communication. Defective speech was found in 46 children (4.5 per cent). Minor defects occurred in 36. Ten were classified as health and adjustment handicaps. Of the ten, six were diagnosed as lisping, two as stuttering, one as defective articulation, and one as cleft-palate speech. The child with defective articulation had a previous diagnosis of macroglossia with a resulting open bite. Both this child and the child with the cleft palate had received as much surgical correction of their oral defects as was feasible.

Of the 95 children with hearing losses, 11 were found to have defective speech. In three cases, it was felt that the hearing loss contributed to the defective speech. In the remaining eight cases, speech and hearing defects appeared to be unrelated.

Summary and Conclusions

The hearing conservation program in Hawaii has been operating under certain assumptions growing out of national experience. Authorities in the field have argued that early detection and conservation through medical treatment result in ultimate savings to the taxpayer. Early detection is, however, not inexpensive because the audiometer in the hands of skilled and experienced personnel is still the only satisfactory case-finding method.

The major findings of this study were:

1. Nine per cent (95) of the sample of fifth-graders tested showed a significant loss of hearing.
2. In 71 per cent of the 95 children with hearing impairment, the defect was not known to the school nor parents.
3. Racial ancestry was not found to be related to incidence of hearing loss.
4. Six children had impairment in speech, and therefore a potential educational and social handicap. In one of these cases, both parents and school were unaware of the condition. Further follow-up seemed indicated in four of the six cases.
5. Of the 969 children with normal hearing on the day of the examination, six per cent were found to have otologic conditions such as otitis media, allergic rhinitis, hypertrophied tonsils and adenoids, or chronic sinusitis.
6. In 46 children defective speech was found; of these, ten were classified as health and adjustment handicaps. Of the 95 children with impaired hearing, 11 were found to have defective speech; in three cases the speech was felt to have been related to the hearing impairment.

[12] Hearing losses generally fall in three categories: *Conductive:* Failure of air vibrations to be adequately conducted to the cochlea, as evidenced by depressed air conduction, normal bone conduction, and damage or obstruction of the ear canal, drum membrane, or the ossicular chain of the middle ear. *Perceptive:* A lesion in the subcortical and cortical auditory areas or in the cochlea as evidenced by air conduction and bone conduction depression. This depression usually occurs in the high frequencies. *Mixed:* Having both conductive and perceptive elements. (Travis, L. E., 1957, Handbook of speech pathology, New York, Appleton-Century-Crofts, Inc.)

[13] A history of two months or more of purulent drainage with no associated acute rhinitis.

Home-cured pork is good, but it
can have some pretty serious consequences

Trichinosis

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FRANK L. MILLER, LT. COL., MC, USA, Honolulu, and
WILLIAM DITO, CAPT., MC, USA, Washington, D. C.

THE PURPOSE of this paper is to present a detailed report of a patient who recovered from a severe case of trichinosis. Serial observations and laboratory studies were possible almost from the beginning of the illness to the time of complete recovery.

Because overt trichinosis is uncommon and because it is often not recognized due to its protean manifestations, we believe this patient's illness is worthy of report.

Case History

A 40-year-old Caucasian man became ill on October 20, 1957, with intermittent chills and fever. Thinking he had Asian influenza, he treated himself at home with aspirin. Two days later, and for several days thereafter, he noticed intermittent puffiness around his eyes. By October 24, a pounding occipital headache, a stiff neck, and episodes of blurred vision had developed. He became progressively fatigued on the following day, and vomited once. The next day he was admitted to the hospital. He denied having anorexia, cough, sore throat, myalgia, diarrhea, and abdominal or pleuritic pain, but he did complain of headache.

Physical examination at that time revealed a well-developed, well-nourished Caucasian man who appeared moderately ill. His blood pressure was 110/70 and his temperature 102°F. The conjunctivae were injected, but the remainder of the ophthalmological examination was normal. His pharynx was diffusely injected, his neck supple, and the posterior cervical lymph nodes were slightly tender. Fine inspiratory rales were heard over the right posterior midlung field. There was a normal sinus rhythm with a pulse rate of 105 per minute. The remainder of the cardiovascular examination was normal. The abdomen was firm but not rigid, and a nontender spleen tip was just palpable. Neurological examination was normal, as were the remainder of the physical findings. The next day a transient ptosis of the right eyelid occurred.

On October 26 a spinal puncture was done, with an opening pressure of 175 mm of water. No cells were seen and the protein was 21 mg per 100 cc of cerebral spinal fluid. The next day periorbital edema developed. There was also an increase in severity of the conjunctivitis. The neck muscles were tender, but there was no meningismus. The eosinophil count was 25 per cent of the white blood cell count. Funduscopic examination remained normal.

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For the first time, a firm, nontender liver edge was felt two fingerbreadths below the costal margin. Trichinosis was considered the most likely diagnosis at this time.

Intermittent daily spiking temperature elevations continued. On October 28 the lungs were clear to auscultation and a chest roentgenogram was normal. The spleen had descended to two fingerbreadths below the costal margin. The next day the patient complained of numbness over his left lateral thigh and buttock, which was without objective counterpart. A sternal bone marrow examination that day showed only relative eosinophilia. The patient stated that his headache was almost gone. On October 30 the scattered rales were heard again over his lungs and another spinal puncture was done which was normal in all respects. At this time the patient had a short attention span and loss of memory for recent events, and was quite drowsy. Despite over-all flattening of his affect, there were spontaneous crying spells and generalized tremors. On the evening of October 30, his mental status was much worse. He stared into space and responded very slowly to questions, although his answers were appropriate. At this time it was learned that his complement-fixation test for trichinosis was negative. In view of this and his deteriorating condition, the diagnosis was changed to "suspected brain abscess." On October 31 he became anorectic. His mental condition remained the same, and his lungs had become free of rales. There were no focal neurological signs.


CAPT. JOY

He was transferred to Walter Reed General Hospital the same day with a diagnosis of encephalitis, acute, cause unknown, and suspected brain abscess or brain tumor. On the day of transfer he received 2,400,000 units of penicillin and 2 g of streptomycin.

On admission he had a blood pressure of 100/60, a temperature of 102°F., a pulse rate of 130 per minute, and respirations of 25 per minute. He appeared acutely ill and showed some evidence of recent weight loss. He was lethargic, toxic, and very slow to respond to questions. He was oriented for space and time but was completely unable to subtract serial sevens and was very uncertain about details of his previous hospitalization.

There was slight periorbital edema, and the conjunctivae were slightly injected. The pupils were reactive and equal, the extraocular movements were normal, and the fundi were unremarkable. The pharynx was slightly red

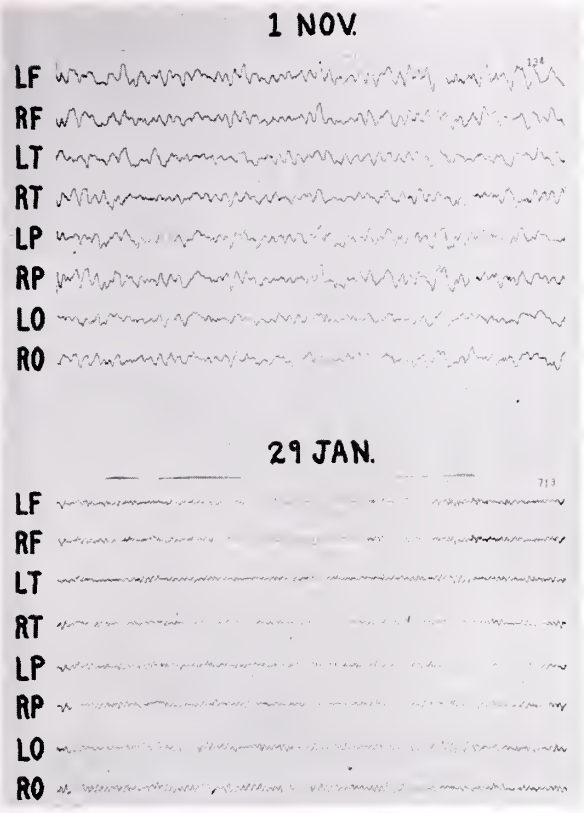


FIG. 1.—*Electroencephalogram November 1, showing diffuse, nonlocalizing abnormalities, without a specific focus of abnormal activity. Electroencephalogram, January 29, normal. (Areas of electrode placement: LF—left frontal; RF—right frontal; LT—left temporal; RT—right temporal; LP—left parietal; RP—right parietal; LO—left occipital; RO—right occipital).*

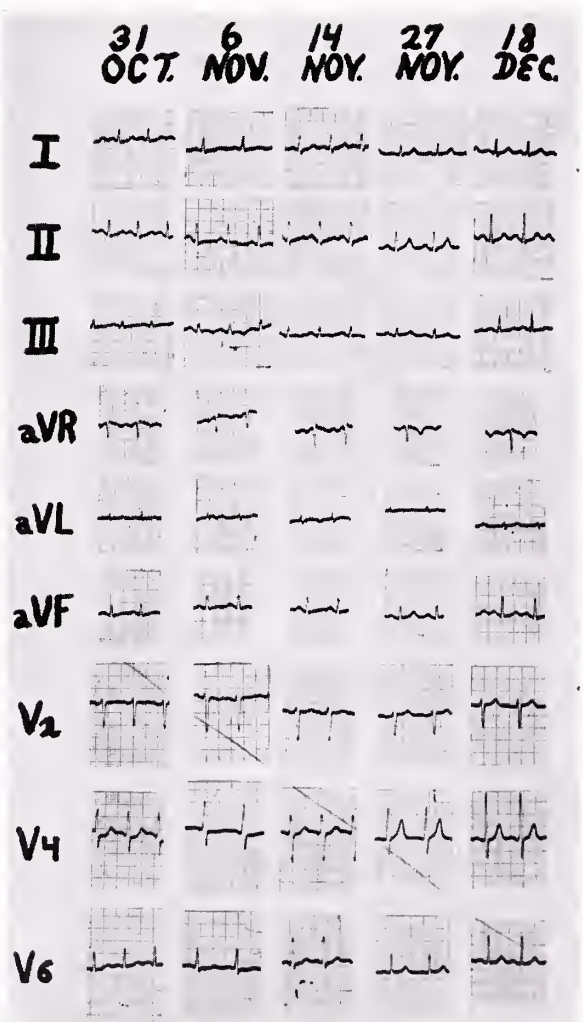


FIG. 2.—*Selected serial electrocardiograms.* **Comment:** *The most prominent abnormality, other than the obvious tachycardia, is seen in the T-waves which progress to complete inversion on November 6, with the most marked changes in leads III and AVL. There is a gradual return to a normal pattern by December 18. The ECG changes are nonspecific, and are seen with any type of myocarditis or primary muscle disease of the heart.*

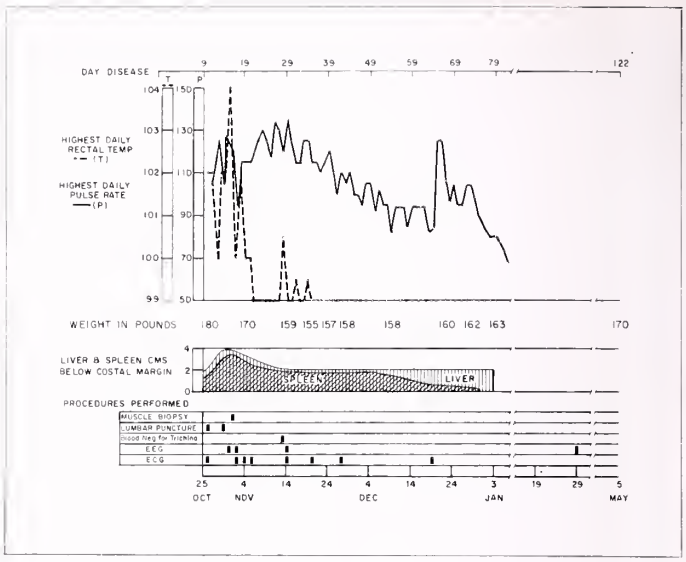


FIG. 3.—*A graphic representation of clinical findings throughout the illness of this patient.* **Comment:** *The marked weight loss is obvious. Particularly evident is the marked dissociation of the pulse and temperature. Tachycardia, associated with the T-wave changes in the serial electrocardiograms, established the diagnosis of myocarditis.*

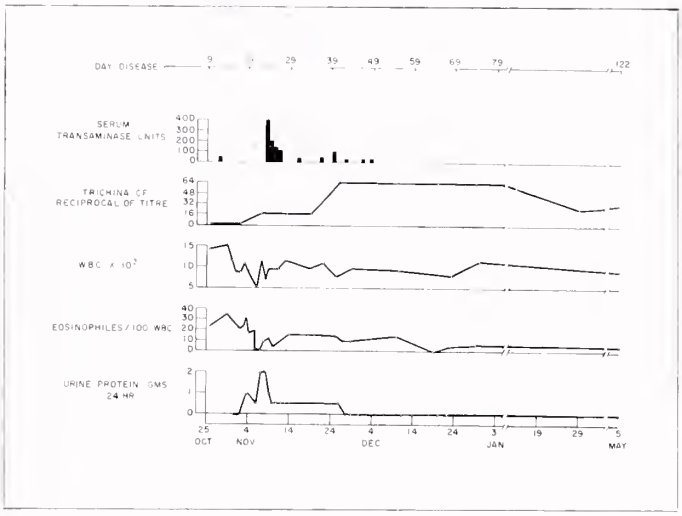


FIG. 4.—*Graphic representation of laboratory findings throughout course of patient's illness.* **Comment:** *While the spleen was maximally enlarged, November 2 to 10, platelet counts averaged 6,800 per cu mm. Beginning November 14, all successive platelet counts were in the normal range of 200,000 per cu mm, indicating probability of hypersplenism with secondary (and temporary) thrombocytopenia. Only laboratory evidence of disturbed liver function was elevated serum transaminase, due, possibly, to involvement of cardiac and skeletal muscle by the parasite. A transient nephrotic syndrome is demonstrated by the brief period of albuminuria from November 2 to 10. On November 10 the serum protein reached its lowest level of 5.7 g per 100 ml, 2.7 g of which was albumin. Cholesterol remained normal. Eosinophile count had returned to essentially normal levels by December 24. Trichina complement-fixation did not become positive until second week, but was still significantly elevated on May 5.*

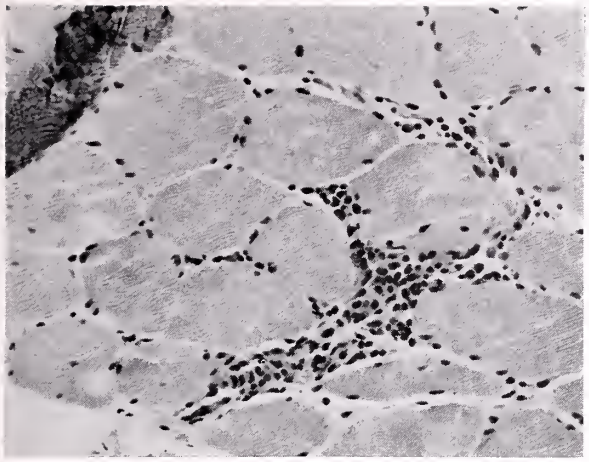


FIG. 5.—*Cross section of deltoid muscle biopsy (hematoxyln and eosin stain 240x), showing scattered extensive foci of chronic interstitial inflammation. Infiltrate is mainly lymphocytes and an occasional plasma cell. Eosinophils are rare.*

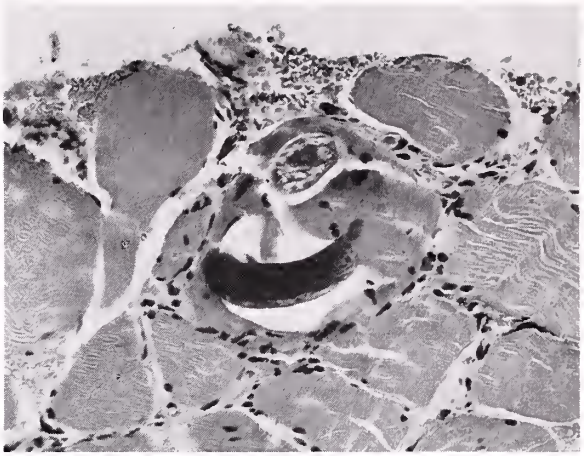


FIG. 6.—*Cross section of deltoid muscle biopsy (hematoxyln and eosin stain 240x), showing a trichina larva. A mild chronic inflammatory reaction exists about the parasite and includes the adjacent sarcolemma. No calcification is seen. Parasite is sectioned both longitudinally and in cross section.*

but free of exudate. Respiratory movements were normal and the lungs were clear to auscultation and percussion. The heart was not enlarged. The rate was 130 per minute, the rhythm was normal, and no murmurs or abnormal heart sounds were heard. The liver was not displaced but was enlarged downward, with the lower border being palpated 4 cm below the right costal margin. The spleen was soft and nontender, and its lower border was felt 3 cm below the costal margin.

The neurological examination was normal in all objective tests. The remainder of the physical examination was normal. Trichinosis was the provisional diagnosis.

An electroencephalogram was performed on November 1 (Fig. 1).

Spinal fluid, under normal pressure, was normal, and no trichina larvae were found in it. The spleen was now 4 cm below the costal margin. For the next two days mental deterioration continued. The patient was incontinent of urine, was unable to feed himself, and was very drowsy. On November 2 a left deltoid muscle biopsy was done and sections confirmed the diagnosis of trichinosis (Figs. 5 and 6). Examination of the fresh specimen crushed between two slides did not reveal larvae, nor were any found on inspection of 50 ml of laked fresh blood. On November 3 we were able to talk with the patient's wife for the first time and she informed us that from September 12 to October 6 the patient had been on leave at his home in Tennessee, where home-slaughtered and home-cured pork was a dietary staple.

On November 4 the patient appeared somewhat clearer mentally and his temperature was lower. Albuminuria appeared and persisted for ten days (Fig. 4). The liver and spleen were still palpable, but neither were tender. Bilateral fine crepitant rales were heard at both lung bases posteriorly. On November 7 he was more responsive mentally. He was afebrile, but his sleeping pulse was still as high as 130 per minute. By November 15 he had a completely clear sensorium but was extremely tired and lethargic. He began to feed himself. His chest roentgenogram remained clear. His venous pressure, with the antecubital vein at the level of the right atrium, was 80 mm of water and his Decholin arm-to-tongue circulation time was 10 seconds. He was now able to confirm that he had eaten home-slaughtered and home-cured pork while on leave in Tennessee.

By November 25 he was considerably better. He had gained 10 pounds and was growing stronger and less tired each day. A few fine rales could still be heard at the lung bases, and the spleen remained palpable 1 to 2 cm below the costal margin. The muscles were not tender.

He did well at home during the Christmas holiday, and was up and around during a three-week leave in January. His electrocardiogram (Fig. 2) and electroencephalogram (Fig. 1) had returned to normal. At no time in his hospital course could a gallop rhythm be heard on cardiac auscultation. His only therapy was aspirin, as sodium salicylate, 5 g daily, from November 1 to December 25.

On February 6, 1958, he returned to duty with a six-month exemption from strenuous physical activity over prolonged periods of time. When the activity limitation was lifted, he was judged to be completely recovered.

Summary

A classical case of trichinosis is reported in detail.

Multiple system involvement is demonstrated by the occurrence of myositis, conjunctivitis, ocular palsy, myocarditis, bronchiolitis, encephalitis, hepatitis, a nephrotic syndrome, and secondary hypersplenism with thrombocytopenia.

It is hoped that the "textbook picture" of trichinosis as it was manifested by this patient may increase the awareness and recognition of an uncommon but not rare disease.

Reprint requests should be directed to Lt. Col. Miller at Tripler General Hospital, Honolulu, Hawaii.

Rheumatic heart disease is about as prevalent in college freshmen in Hawaii as it is on the mainland, and less than half its victims are receiving proper prophylactic medication.

Rheumatic Fever and Rheumatic Heart Disease In University of Hawaii Freshmen

THOMAS C. McBRIDE, M.D.,* Amherst, Massachusetts

EXCLUDING malignancy, rheumatic heart disease ranks as a major cause of death and disability in the college age group. An extensive survey of college freshmen by R. P. Sandidge *et al.* has shown a prevalence rate of 25.4 per 1,000 students for rheumatic fever and a rate of 7.8 per 1,000 for rheumatic heart disease.[1]

It is now generally agreed that infection with group A hemolytic streptococci precipitates both initial and recurrent attacks of rheumatic fever. For this reason, the American Heart Association has supported the use of chemoprophylaxis since 1953.[2] All patients who have a well-documented history of rheumatic fever or chorea, or who show definite evidence of rheumatic heart disease, should be given continuous prophylaxis.[3]

In spite of this, Sandidge demonstrated that of the college students who should be currently receiving prophylaxis, only 11.6 per cent are actually taking regular prophylactic medication.[1]

Purpose of Study

It was deemed that a comparison of data obtained from mainland college freshmen and University of Hawaii freshmen would be helpful in evaluating the relative prevalence of rheumatic fever and rheumatic heart disease in Hawaii. Previously unknown cases of rheumatic heart disease could be uncovered by a careful survey which included physical examination.

We also wished to evaluate the effectiveness of the rheumatic fever prophylaxis program in the state. The suspicion that prophylaxis was not being fully applied needed to be documented, in order that the attention of student health workers could be directed toward this possible health need.

This study was a joint project of the University of Hawaii Student Health Service, the U. S. Public Health Service, the Hawaii State Department of Health, and the Hawaii Heart Association. By actually including all interested groups in the study, it was felt that attention might be focused on the early detection and medical care of heart disease in the young adult group.

The Study Population

It was decided that the University of Hawaii freshman class (those matriculating in September, 1960) would be a suitable group to study. All students entering the University are required to submit a history and physical examination form from their private physician as part of their entrance requirements. Those students who have either a history of cardiac disease, including rheumatic fever, or who have heart murmurs or other cardiac findings are ordinarily re-examined by the University physician.

College students are young enough to recall the details of childhood illness and the medication they may have received. They would also be expected to have benefited from the programs of prophylaxis against rheumatic fever during the past decade. The medical care given to college students would be equal to, if not better than, that of a noncollege group.

Table 1 describes the composition of a group of 31 students from the total sample of 2,055 who were studied intensively because of a history of rheumatic fever or cardiac physical findings.

---

* Dr. McBride was an officer of the U. S. Public Health Service, Heart Disease Control Program, assigned to the Hawaii State Department of Health, until June, 1961.

[1] Sandidge, R. P., Nielsen, A. L., and Evans, M. A.: Rheumatic fever and rheumatic heart disease among college freshmen, Student Medicine 8:122-136 (Dec. 1) 1959.

[2] Breese, B. B., Bellows, M. T., Fischel, E. E., Kuttner, A., Massell, B. F., Rammelkamp, C. H., and Schlesinger, E. R.: Prevention of rheumatic fever, Circulation 7:316-319 (Feb.) 1953.

[3] American Heart Association: Prevention of rheumatic fever and bacterial endocarditis through control of streptococcal infections, 2d rev., Circulation 21:151 (Jan.) 1960.

TABLE 1.—*Composition of Student Sample*

Total number of freshman students in rheumatic fever survey	2,055	
Students examined by college physician because of heart murmur or history of rheumatic fever (1.5% of 2,055 students)	31	
SEX—		
Total	31	100%
Male	12	39%
Female	19	61%
RACE—		
Total	31	100%
Japanese	18	58%
Caucasian	9	29%
Part-Hawaiian	3	10%
Chinese	1	3%
AGE—		
Youngest	17	
Oldest	33	
Median age	18	
HOME RESIDENCE—		
Total	31	100%
Honolulu	18	58%
Oahu (other than Honolulu)	5	16%
Kauai	3	10%
Maui	3	10%
Mainland U. S. A.	2	6%

Method of Study

The plan of this study and the form of reporting its findings closely follows that of Dr. R. P. Sandidge[1] with certain modifications. The data used in the study were obtained by questionnaire through cooperation of the physicians of the community and the Student Health Service.

The questionnaire was composed of two parts, one to be completed by the student and the other by the examining physician. All entering freshmen completed a brief self-history, answering questions pertaining to: (1) manifestations of rheumatic fever and its sequelae, (2) previously having been told by a physician of the presence of rheumatic fever. Those students who had been told they had rheumatic fever were asked to answer additional questions as to the number of attacks, the age at which attacks occurred, whether medication was given, the kind given, how long it was continued, and whether it was still being taken at the time of completing the questionnaire.

The second section was completed by a physician for all students with a positive or suspected history of rheumatic fever, or with rheumatic heart disease. The physician indicated whether, in his opinion, there was a valid history of rheumatic fever, and reported any physical evidence of the presence or absence of heart disease disclosed during the physical examination.

An effort was made to validate the data from all students with a history of rheumatic fever or with heart murmurs. Hospital records were reviewed, and every student under consideration was seen and examined by at least two physicians. A group of students about whom there was some doubt as to the definitive diagnosis were seen in special cardiac consultation. This consultation consisted of a thorough history and examination by an internist, a complete x-ray evaluation of the heart (including fluoroscopy and barium swallow), an electrocardiogram, and an erythrocyte sedimentation rate.

TABLE 2a.—*Prevalence of Rheumatic Fever and Rheumatic Heart Disease Among 2,055 University of Hawaii Freshmen Examined During 1960-61*

HISTORY OF RHEUMATIC FEVER	TOTAL		DEFINITE RHEUMATIC HEART DISEASE		PROBABLE RHEUMATIC HEART DISEASE	
	No.	*Rate Per 1,000*	*No.*	*Rate Per 1,000*	*No.*	*Rate Per 1,000*
Total*	14	6.8	5	2.4	9	4.4
Definite history	5†	2.4	3	1.4	2	1.0
Questionable history	7	3.4	0	0	7	3.4
No history	2†	1.0	2	1.0	0	0

* Total positives include all students with a history (definite or questionable) of rheumatic fever and/or rheumatic heart disease (definite or probable).
† These students (total 7) are considered "definite positives," i.e., having either a definite history of rheumatic fever or a definite diagnosis of rheumatic heart disease. The prevalence for this group is 3.4.

TABLE 2b.—*Prevalence of Rheumatic Fever and Rheumatic Heart Disease Among Mainland College Freshmen (Sandidge, Nielsen, Evans)*[1]

HISTORY OF RHEUMATIC FEVER	TOTAL *Rate Per 1,000*	DEFINITE RHEUMATIC HEART DISEASE *Rate Per 1,000*	PROBABLE RHEUMATIC HEART DISEASE *Rate Per 1,000*
Total	25.4	2.9	4.9
Definite history	15.6	2.2	2.2
Questionable history	7.8	0.3	1.1
No history	2.0	0.4	1.6

Findings

During the school year of 1960-61, questionnaires were completed by 2,055 entering freshman students (see Table 2a).

While the majority of students were found to be negative for purposes of this study, there were 14 students who were diagnosed as having either definite or questionable histories of rheumatic fever, or physical findings of rheumatic heart disease. This represents a prevalence rate of 6.8 per 1,000 students, compared to a rate of 25.4 per 1,000 in mainland colleges (see Table 2b).

The prevalence rates of rheumatic fever by history, either definite or questionable, appears to be considerably lower in Hawaii than in mainland colleges. However, the Hawaii rates for rheumatic heart disease as diagnosed by physical examination are quite similar to mainland rates. The rate for definite rheumatic heart disease is 2.4 per 1,000 and for probable rheumatic heart disease 4.4 per 1,000, in Hawaii.

Two students were found to have definite rheumatic heart disease without any previous history of rheumatic fever. This finding demonstrates the value of a careful cardiovascular examination in college students.

Table 3 illustrates the type of rheumatic heart lesions diagnosed in the total group of 14 students. Mitral insufficiency and mitral stenosis were the most common valvular lesions.

TABLE 3.—*Rheumatic Heart Disease Diagnoses* (Definite and Probable)

	NO.
Total cases of rheumatic heart disease	14
Mitral insufficiency	12
Mitral stenosis	6
Aortic stenosis	2
Disturbances in rhythm and/or conduction	2
Aortic insufficiency	1

Note: Individual case may have more than one valvular lesion.

Of the 12 students who gave a definite or questionable history of rheumatic fever, eight had had only one attack. Four students experienced recurrent attacks of rheumatic fever, with one student suffering four recurrences of rheumatic fever.

TABLE 4.—*Students with Recurrent Attacks of Rheumatic Fever*

	RECURRENT ATTACKS	
	NO.	%
Total*	12	100
No recurrent attacks	8	67
With one or more recurrent attacks	4	33
Two recurrent attacks	3	25
Four or more recurrent attacks	1	8

* The total number of students with a definite or probable history of rheumatic fever.

Prophylaxis

The American Heart Association recommends prophylaxis in "all patients who have a well-documented history of rheumatic fever or chorea, or who show definite evidence of rheumatic heart disease" and that "the safest general procedure is to continue prophylaxis indefinitely, particularly if rheumatic heart disease is present." "Prophylaxis should be initiated as soon as the diagnosis of rheumatic fever is made or when the patient is first seen in the case of inactive rheumatic fever."[3] If this recommendation were followed, all students with a history of rheumatic fever or findings of rheumatic heart disease who were told of their condition by their physician should have been on continuous prophylaxis.

Of the 31 students in this study who had either a history of rheumatic fever or a heart murmur, 14 had previously been told that they had rheumatic fever or had been found to have heart disease. This group should definitely have been receiving prophylaxis for the prevention of recurrent rheumatic fever.

Table 5 shows that only 71 per cent had been on prophylaxis and only 43 per cent were taking prophylactic medication at the time this study was conducted.

TABLE 5.—*History of Prophylaxis for Prevention of Rheumatic Fever*

	NO.	%
Total who should have been on prophylaxis	14	100
Previously on prophylaxis	10	71
Currently on prophylaxis	6	43

Table 6 shows that of patients with definite rheumatic heart disease, 75 per cent were on prophylaxis at the time of the study, compared to only 20 per cent of those with a probable diagnosis of rheumatic heart disease.

TABLE 6.—*Students Who Should Have Been on Prophylaxis by Heart Disease Status*

	TOTAL NEEDING PROPHYLAXIS	CURRENTLY ON PROPHYLAXIS
Definite rheumatic heart disease	4	3
Probable rheumatic heart disease	5	1
No rheumatic heart disease	5	2
Total	14	6

Other Forms of Heart Disease

In the screening of over 2,000 students of the freshman class, 31 were studied in some detail because of a history of rheumatic fever or positive cardiovascular physical findings. Table 7 illustrates the final clinical impression regarding this group. A total of 45 per cent was found to have definite or probable rheumatic heart disease. The second most prevalent condition was that of functional heart murmur, found in 29 per cent.

TABLE 7.—*Diagnoses of 33 Students with Heart Murmurs or History of Rheumatic Fever*

	NO.	%	
Total students with murmur or history of rheumatic fever	31	100	
No heart disease	4	13	
Definite rheumatic heart disease	5	16	45%
Probable rheumatic heart disease	9	29	45%
Probably no heart disease (functional murmur)	9	29	
Probable congenital heart disease	3	10	
Other heart disease	1	3	

Discussion

The survey of this group of 2,055 students proved rewarding even for the relatively small number of heart patients found. The fact that 14 per cent of students with rheumatic heart disease had no previous history of rheumatic fever proves the value of the entrance physical examination in college students. A history alone is not adequate to screen for cases of rheumatic heart disease. Physical examination, if carefully performed, can be expected to yield not only rheumatic heart cases, but also a significant number of other cardiac problems such as congenital heart disease and functional murmurs. In many instances there has not been adequate clinical evaluation of these cases by the time they enter college. This is an important health need of students who are entering the valuable and active years of higher education and adult life.

A comparison of prevalence rates of rheumatic fever by history seems to show significantly lower rates in Hawaii. This may be due to unrecognized cases of acute rheumatic fever or possibly some variation in signs and symptoms of the disease in the islands. The similar prevalence of actual rheumatic heart disease in Hawaii and on the mainland suggests that acute attacks of rheumatic fever may be unrecognized.

The suspicion that only a small proportion of "rheumatics" are receiving effective continuous prophylaxis is supported by this study. Less than half of those cases in which there is virtually universal agreement on the need for prophylaxis are currently receiving medication. This is indeed discouraging in view of the availability of medication through the low cost penicillin program of the Hawaii Heart Association and the value of such prophylaxis. Thus is demonstrated a need for further professional and patient education.

It is expected that this preliminary study will serve as a model for the collection of data over a five-year period at the University of Hawaii. With the acquisition of a larger number of cases, differences from the mainland in prevalence, racial differences, and frequency of recurrence may be described in detail.

Summary

1. During the school year 1960-61, 2,055 freshman college students at the University of Hawaii completed questionnaires in the study of rheumatic fever and rheumatic heart disease. Of these, 14 had either a definite or questionable history of rheumatic fever or findings indicative of rheumatic heart disease. This represents a prevalence of 6.8 per 1,000 (see Tables 2a and 2b), and is about one-fourth of the mainland rate.

2. There were five students with definite rheumatic heart disease and nine with probable rheumatic heart disease, representing prevalence rates similar to those found in mainland colleges.

3. Of those 14 students with rheumatic heart disease, two students (14 per cent) had no previous history of rheumatic fever (Table 2).

4. Of the 14 students who should, by present standards, have been on prophylaxis, only ten (71 per cent) have ever been on prophylactic medication, and only six (43 per cent) were still on prophylaxis at the time of completing the questionnaire (Table 5).

5. Rheumatic heart disease is the most common cardiac condition in the freshmen students.

6. The value of careful cardiac evaluation of all students and the need of prophylactics for students with inactive rheumatic fever and actual rheumatic heart disease has been demonstrated.

Acknowledgment

The author is grateful to Dr. Roy P. Sandidge for use of his protocol and questionnaires in this study. The assistance of Dr. Carolina Wong and Dr. Ione Rathburn, of the University of Hawaii; Dr. Norman Sloan, of the Hawaii State Department of Health; Mr. Martin Covitz, of the Hawaii Heart Association; and Dr. Noboru Oishi and Dr. George Henry of Honolulu was greatly appreciated.

480 Pleasant St.

Stop King-Anderson—

join AMPAC!

The President's Page



DR. BURDEN

Hearings on the problems of the aged, conducted by Senators Long and Morse, members of the special Senate Committee on Aging, started in Honolulu on November 27 and were followed by hearings on Kauai, Maui, and Hilo. The Honolulu hearing was the largest and best attended. In all, 39 statements by various departments and organizations were made, and it was significant that only those made by union organizations stated that the care of the aged in Hawaii was inadequate and actively endorsed the King-Anderson Bill. Also significant, and heartwarming, was the "Town Hall" portion of the hearing when the oldsters had a chance to express their opinions. One and all stated that they wished no further handouts from the Federal Government, that if the government would help in furnishing good housing at a reasonable rent, and give them some tax relief, they could look out for themselves!

This does not mean that we can forget about the King-Anderson Bill. We must constantly remind ourselves that the Administration has committed itself to the passage of this bill in the coming session, and leave no stone unturned in our efforts to help prevent this. Senator Wayne Morse remarked, during the Maui hearing, "Socialized medicine is bound to come so why don't you doctors realize it and adjust yourselves to it."

In preparing for these hearings, I was impressed with the lack of knowledge about the bill. Lay people would say "Oh yes, that is the bill to provide medical care for the aged. I think that is a good bill and should be passed," but when apprised of the provisions of the bill they quickly changed their opinion and were against it. Among physicians I found equal ignorance. All knew that it was a bill tying medical care to Social Security, and that the AMA was against it, but no one knew what the provisions of the bill were. The usual answer was "I don't know enough about the bill to talk about it." It seems almost incredible that we as physicians should be so little concerned with a bill that threatens our rights to practice medicine as we see fit, a bill which without question would be the entering wedge by which those who wish to socialize medicine could socialize the nation. Yet not one in ten of us is sufficiently informed about the bill to talk intelligently against it, to our friends or our patients.

The Kerr-Mills Law, which has been in effect in Hawaii since July 1, 1961, offers the mechanism for providing complete medical, surgical, and hospital care to those financially in need of assistance. It leaves control of the disbursing of this care at the State level where local problems can be understood and handled intelligently.

The King-Anderson Bill would put control of the medical care of the aged in the hands of a Washington bureaucracy. In addition the care provided is not complete, and is not limited to those needing assistance but to all who are covered by Social Security. It provides no care for anyone not covered by Social Security, regardless of need.

The King-Anderson Bill provides only limited care. No physicians' bills are covered. Diagnostic work is covered only when done in hospitals approved by the Department of Health, Education and Welfare, and the patient has to pay for the first $20 each time. When hospitalized the patient must pay $10 towards each day's care up to and including the ninth day. This presents the patient with a $90 bill for each illness, a sizable amount for the medical indigent to have to pay.

Despite these deficiencies the Administration is backing this bill because it puts control of hospital care in the hands of the Government, and once passed, the law can be expanded and changed in any manner the Government sees fit. It is also backed by the unions, and this is harder to understand. In an address to the ILWU Pensioners Association, Jack Hall stated "One of the greatest problems of the aged is the lack of adequate medical care" and then went on to urge all the pensioners to vote against anyone not backing the King-Anderson Bill, intimating that this bill was the answer to "adequate medical care."

Another sidelight resulted from these hearings. On Maui Senator Morse stated the intent of the Kerr-Mills Law was that any medical indigent was entitled to a free choice of physician so he could go to his family physician and yet receive aid from Kerr-Mills funds. In Hawaii, as far as I can find out, the family physician still has to agree to take care of the patient for nothing, or the patient has to go to a government physician. This problem has been taken up with the Department of Social Services, to clarify the law and rectify this situation if possible.

* * *

As this is being written, your Federal Medical Services Committee is negotiating a new and improved fee schedule with the Veterans Administration. We will have more details on this in the next issue.

* * *

Plans are progressing for the Annual Meeting on Maui, May 3-6. The program committee is shaping up an outstanding program and there is a possibility that Dr. Annis may be able to attend. One problem presents itself: the limited hotel space available, and the active demand for this space by tourists, necessitating early reservations in order to assure sufficient space. All who plan to attend are requested to fill out the information and reservation cards and send them in to the committee soon.

We hope your Holiday Season was a very merry one.



Hawaii
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[EDITORIALS]

AMPAC

We believe defending the public health is a clear obligation of medicine and that every physician should give his wholehearted support to the high objectives of AMPAC.

—Report of the Reference Committee on Legislation and Public Relations to the House of Delegates of the American Medical Association, Denver, Colorado, November 29, 1961

The American Medical Political Action Committee (AMPAC) was organized shortly before the Fifteenth Clinical Meeting of the AMA in Denver, two months ago. Its purposes are as follows:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.
2. To encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records and positions of political parties, officeholders, and candidates for elective office.
3. To assist physicians and others in organizing themselves for more effective political action and for carrying out their civic responsibilities.
4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

The organization, which is separate and distinct from the American Medical Association, accepts support not only from physicians but from their wives and from interested laymen. It is hoped that all physicians will follow the lead of most of the members of the House of Delegates, who contributed $99 each before the end of the meeting in Denver. A larger contribution must be acknowledged as a political contribution. AMPAC does not take the place of local political action organizations, but helps them at the national level.

AMPAC's principal immediate objective—which was responsible for the exciting sense of its urgent importance at the Denver meeting—is to secure the defeat of the King-Anderson Bill, which would place hospital care for all OASI beneficiaries over 65, rich and poor alike, on a Social Security basis.

The AMA attitude was summarized eloquently by President Leonard W. Larson in his address, as follows:

1. We are *for* voluntarism.
2. We are *for* an improved public attitude toward older citizens, and their integration into the mainstream of society.
3. We are *for* measures designed to protect the earning capacity of those who can take care of themselves.
4. We are *for* a free profession, not an enslaved one.
5. We are *for* the preservation of our constitutional republic; we are opposed to a welfare state.
6. We are *for* the right of our citizens to spend their dollars in their own way, not for Washington authoritarians to spend their money for them.

If the King-Anderson Bill passes, its extension to include medical and surgical services outside the hospital, and progressively younger "beneficiaries," will require only a few simple amendments, and seems almost inevitable. Wilbur Cohen envisions a Social Security tax, within the next 20 years or so, as high as 20 per cent, on all earnings up to $9,000. This would cost more than all other government functions and expenditures put together. And the Assistant Secretary of Health, Education and Welfare—Wilbur Cohen—testified in a Senate hearing last March that he thought this was right and proper.

At the moment, your financial support of AMPAC and your efforts to recruit additional members to it are the most effective things you can do to prevent this from happening. This is the clear duty of thoughtful, responsible citizens everywhere, and it is *your* clear duty, too. *This* brand of Socialism isn't even creeping. Send in your check—right now!

The Hawaii Birth Rate

The birth rate (number of births per 1,000 population) for Hawaii is usually computed in the State Health Department, using as a base the civilian population, which excludes military personnel but includes their dependents. Computed in this way, the rate for the calendar year 1960 was 28.9. This is about 22 per cent higher than the national provisional rate of 23.6 for the same year.

Using military personnel as well as their dependents in the population base, the Hawaii rate becomes 26.5, still well above the national average.

Recently, the estimated number of military dependents in Hawaii was secured from military authorities. Using this estimate, a rate was computed excluding both the military and their dependents. The result was 22.6, somewhat below the national average.

Still another rate was then computed for the military and their dependents only—excluding the entire nonmilitary population. This computation resulted in a rate of 44.9, which is about double the nonmilitary rate in Hawaii.

This high birth rate for military families indicates that Hawaii's over-all rate is raised by an influx of young military couples who generally fall in the highest child-bearing age-group. They are stationed here for a few years, have children, and then move on to be replaced with other young couples. Thus, we have a constantly replenished reservoir of fertility.

It is estimated that military personnel and their dependents constituted about 18 per cent of Hawaii's 1960 population. Although substantiating data are not available, possibly no other state has so high a proportion of its population who are the wives and other dependents of armed forces personnel.

Aloha, Nurses!

The HAWAII MEDICAL JOURNAL became the HAWAII MEDICAL JOURNAL AND INTER-ISLAND NURSES' BULLETIN just 15 years ago. We have had more nurse than physician subscribers ever since. It has been a happy relationship: the nurses have had eight or ten pages of text and pictures in their own section of the magazine, and have received it at less than cost; the doctors have had the advantage of higher advertising rates because of the larger number of subscribers.

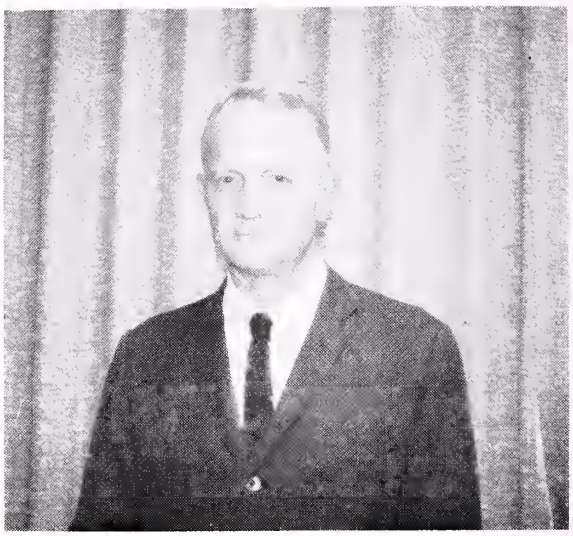
With the next issue, the HAWAII MEDICAL JOURNAL will again be, except for the section given over to the "med. techs," entirely a doctors' publication. The nurses' long-standing restlessness and their desire for their own independent bulletin has finally ended in their withdrawal from our joint venture.

Our advertising rate will not change as a result, and we anticipate no significant loss of advertising revenues. The subscription rate has already been raised to $6 as of this calendar year.

We think this joint publishing effort has been worth the trouble and expense, though it seems likely that the nurses have in general been more interested in the doctors' portion of the magazine, than the doctors have been in the nurses' section. But we applaud the formation of a new, independent publishing venture, and wish it all possible success. Aloha, nurses!

Don't miss NEWS & VIEWS, *page 214*

Report of the President of the Western Conference of Pre-Paid Medical Service Plans



DR. JOHN P. FRAZER, M.D.
President, Western Conference of Pre-Paid Medical Service Plans

With my election as an officer of the Western Conference of Pre-Paid Medical Service Plans, of which HMSA is a member, I have found my association with members of the Conference to be most stimulating and educational.

The Western Conference of Pre-Paid Medical Service Plans is composed of Service Plans in the Western Provinces of Canada and the Western United States.

Some of the problems experienced by HMSA in the past are presently being confronted by other plans. Through the media of the Western Conference HMSA has benefited other plans and themselves with an interchange of ideas and experiences.

It is refreshing to see the dedication of both professional and laymen to the principles of their plans, and I am equally impressed with the prominence and validity our HMSA Plan has in the eyes of other plans of the Conference.

The conferees at these Conferences are aware that their plans must work *NOW* before Government takes the initiative from them.

The socialization of hospitals throughout Canada has been responsible for limiting the hospital efficiency and has cost far more than anticipated.

Socialized medicine is a threat and physicians must provide for the needs of their patients on a voluntary, "free enterprise system."

HMSA®

"HMSA NO KA OI"

HAWAII MEDICAL SERVICE ASSOCIATION

(Advertisement)

This is What's New!

Examination of the neck arteries at the time of autopsy, in patients over 35 years of age, revealed severe narrowing of at least one carotid or vertebral artery in 40 per cent of patients examined. Arteries that tend to come off at right angles, such as the **left common carotid** off the aortic arch, are more likely to have **proximal lesions;** while arteries such as the right common carotid, which is a continuation of the innominate, have a **low** incidence of proximal stenosis. All of this is of course exceedingly important to the neurovascular surgeons who are treating, and in some instances preventing, strokes due to occlusive disease of the carotids. (*Brit. Med. J.* [Oct. 21] 1961.)

Diseases and syndromes often recognized by the most subtle of signs and symptoms now are numbered in the thousands. No head, no matter how big or clever, can possibly retain enough information to diagnose these many conditions. The memory's failure sets a limit to the physician's ability to diagnose. Various mechanical gadgets, such as **slide rules** with signs and symptoms and diagnoses instead of numbers; **punch cards** with holes for various symptoms and signs around the outer edge; and elaborately programmed **computer systems,** have been presented as a substitute for the human memory. A really worthwhile memory substitute would have to sort through the various signs and symptoms present (as well as the *absence* of other symptoms), review the various possibilities, and then come up with a diagnosis including the probability of this being the correct diagnosis; e.g., **Tsutsugamushi disease, 93.5 per cent probability.** (*Ann. Int. Med.* [Oct.] 1961.)

After carefully studying **hereditary** patterns in diabetes, a student of the problem reports that **diabetes mellitus** is probably due to **homozygosity for a recessive gene** (that is, "dd"), and that only one recessive gene is involved. It was impossible to predict age of onset of diabetes even if the diabetic pattern in a parent or sibling was known. (*Diabetes* [July-Aug.] 1961.)

Normal saline eye drops were superior to silver nitrate drops in **preventing gonococcal ophthalmia** of the newborn. Of the various techniques used as prophylaxis in New York hospitals, the use of silver nitrate drops was associated with 25 cases of gonococcal ophthalmia of the newborn in 100,000 births, while the use of normal saline was associated with an incidence of seven cases per 100,000 births. (*Am. J. Pub. Health* [516—836-845] 1961.)

Bristol Laboratories has recently reported a new synthetic penicillin which they have named **Prostaphlin.** Like its predecessor, Staphcillin, produced by the same firm, it is active against penicillinase-producing staphylococci. It appears to have two advantages over Staphcillin: (1) it is extremely well absorbed when **taken orally;** and (2) it is **more active than Staphcillin** against most susceptible organisms. (*New Eng. J. Med.* [Nov. 16] 1961.)

A syndrome **resembling Addison's disease** was found in four patients after long-term **Myleran** therapy. All of the patients were under treatment for granulocytic leukemia by Boston hematologists who were unable to confirm the diagnosis of Addison's disease with laboratory studies. (*Blood* [Nov.] 1961.)

Increased interest is being focused on the diagnosis of the curable disease, primary **hyperparathyroidism.** A Rochester clinic, in reviewing 380 cases with confirmed diagnoses, found that **hypercalcemia,** although sometimes only minimal, was the one finding **essential** to the diagnosis. Renal calculi continued to lead the list as the major diagnostic clue but in over ten per cent of patients, the only clue was an elevated serum calcium discovered by more or less routinely performing serum calcium and phosphorus determinations in patients without associated signs or symptoms of hyperparathyroidism. (*J.A.M.A.* [Nov. 11] 1961.)

A third type of **familial periodic paralysis** has now been described in some detail. The first or classic type is associated with **low serum potassium;** the second, which is graced with the name "hyperkalemic adynamia episodica hereditaria," is associated with **high** serum potassium and paralysis is provoked by potassium chloride; in the third type the serum potassium is **normal,** paralysis may be provoked by potassium chloride and treatment consists of the administration of **sodium chloride.** (*Am. J. Med.* [Sept.] 1961.)

An Icelander recommends **burn** therapy that was taught to him by his mother some 45 years ago. The physician has found that both experimental and clinical results confirm his mother's advice. Rapid cooling of burns and scalds by **cold water** relieves pain and decreases the severity of the local pathologic changes. (*Postgrad. Med.* [Oct.] 1961.)

FRED I. GILBERT, JR., M.D.

In Memoriam - Doctors of Hawaii - XXXVI

This is the thirty-sixth installment of In Memoriam—Doctors of Hawaii.

Luiz Rodriques Gaspar

Luiz Rodriques Gaspar was born in Funchal, Madeira Islands, Portugal, on April 16, 1874. He was the son of Luiz Rodriques and Maria Amelia (Pestana) Gaspar.



DR. GASPAR

He received his medical training at Funchal Medical School, graduating in 1890, and from the University of Coimbra on the mainland of Portugal. Dr. Gaspar interned in London. Attending the University of Brussels, he took additional work in the field of nose and throat.

On July 17, 1902, Dr. Gaspar married Maria Isabel Rodriques in Funchal. The couple had one son, Louis A. R., and a daughter.

Dr. Gaspar began general practice in Funchal. However, following a severe epidemic of smallpox in 1909, in which the Gaspars lost their three-year-old daughter, the doctor came to Hawaii as ship's surgeon on an immigrant liner. Hawaii so appealed to Dr. Gaspar that he returned in 1910 with his wife and son.

He was in practice in Honolulu continuously from 1910 to 1941, when his health failed.

So vitally interested was Dr. Gaspar in the Portuguese community that he gave up his specialty in nose and throat to carry on a general practice among his countrymen.

He also served as vice-consul for Portugal and Cuba.

Dr. Gaspar died November 24, 1944, in Oakland, California, at the age of 70.

He was an Eagle, a Moose, a member of the Oto-Rhino-Laryngology Society of Brussels and of the Lusitana, San Antonio, and San Martinho societies.

George T. Shipley

Dr. George T. Shipley, born in Boston, Massachusetts, and a former surgeon in the U. S. Navy, arrived in Honolulu aboard the "Idaho" February 1, 1869. On July 15, 1869, he was married to Mrs. Mary Virginia Rosalie Fuller in Honolulu, and in October the doctor and his bride left the Islands.

Returning on the "Ajax" May 19, 1870, with his wife and baby, Dr. Shipley settled in Honolulu and opened an office on Fort Street. The following January the doctor went to the mainland to be gone until April 4, 1871, when he returned and resumed his practice at his residence on Fort and Chaplain Streets. The business card advertising his Honolulu office appeared for the last time in the September 30, 1871, edition of the *Pacific Commercial Advertiser*. and this must mark the approximate time of his departure for the Kona District of Hawaii, where he practiced for the next four years.

In 1873 Dr. Shipley was severely criticized in an article in the *Pacific Commercial Advertiser* which claimed he refused to see a patient with an amputated arm sent down by boat from the Naalehu Plantation to Kona to get Dr. Shipley's opinion as to whether he should be treated at Kona or be sent on to Honolulu. A letter from the plantation was sent to Dr. Shipley explaining the situation and asking him to attend the patient. When the ship anchored at Kailua and the patient was put ashore, the Captain also sent a note to the doctor asking him to call at once so that arrangements could be made to take the man on to Honolulu the next day if that seemed advisable. Three days later, when Dr. Shipley had still not seen the patient, the man in whose care the patient had been left wrote urging the doctor to see the patient. The doctor's answer to all these requests was that he was a government physician and unless he was guaranteed a $25 fee he would not come. The patient lived for ten days at Kailua within ten miles of Dr. Shipley but died without any medical attention.

By November, 1875, Dr. Shipley was back in Honolulu with an office at Mr. Strehz's drug store on the corner of Fort and Hotel Streets. Early in 1877 he settled on Kauai where he remained for about two years. In November, 1877, he was appointed a member of the Tax Appeal Board for Koloa and was reappointed the following year. In the fall of 1879 he returned to Hawaii this time to be government physician for the Hamakua District with headquarters at Honokaa.

Dr. Shipley died on December 7, 1880, in Honolulu, at the age of 48.

John Delarma Furry

John Delarma Furry came to Hawaii in the hope that the mild climate would help cure a serious lung condition. Dr. Furry was a native of Canada but came to the Islands from Peoria, Illinois, where he had begun his practice several years before.

He probably arrived some time in 1889 and located in Honolulu with his office at 81 Beretania Street. Although he had been in practice a relatively short time, he was often called in consultation by older medical men of the city, and he took over Dr. Brodie's practice in his absence.

By March, 1891, Dr. Furry was seriously ill, and his father, Mr. Elias Furry, came to Honolulu to accompany his son to the family home in Dunnerville, Ontario. They sailed on the S. S. "Australia" April 7, and made the trip to San Francisco with no ill effects. In San Francisco they waited two-and-a-half days trying to get a drawing room car on an east-bound train but finally had to take a sleeper. Aboard the train Dr. Furry began to fail rapidly and died a few hours after reaching Chicago on April 21. He was in his early thirties at the time of his death.

James Malcolm Thompson

James Malcolm Thompson, a native of Glasgow, Scotland, was a graduate of the Chicago College of Medicine and Surgery in 1910. Later that year he came to Honolulu to serve his internship at The Queen's Hospital, following which he practiced at Lihue, Kauai.

He was married and the father of one son.

Dr. Thompson died on August 5, 1915, in San Francisco at the age of 35.

Book Reviews

★A Manual of Cutaneous Medicine

By Donald Pillsbury, M.D., Walter Shelley, M.D., and Albert Kligman, M.D., 430 pp., $9.50, W. B. Saunders, 1961.

This is a rare book. It considers both the intelligence of the reader and the seat of his pants. The essentials of dermatology have been presented with brevity and wit. In four hundred and thirty picture-studded pages, the authors have not only summarized the basic elements of physiology, chemistry, and anatomy of the skin, but also have presented the essentials of diagnosis and modern treatment of the common dermatoses and a few of the rare ones.

Much medical writing is pedestrian; this book is not. It reads easily and is a factual as well as a fun book. The authors have attempted to reduce the complex dermatologic gobbledygook to readable English. While few epigrams are used in the book, we learn the value of them—for example, in discussing one form of erythema multiforme "this form was originally designated by a term which can be remembered or pronounced only by a select few—ectodermosis erosiva pluriorificialis. For this reason it has come to be known as the Stevens-Johnson syndrome."

An example of the basic approach used by the authors is the excellent clinical presentation of miliaria showing photographs of the condition followed by sketches of its pathogenesis. Then the causes and management are summarized beautifully by a sketch of an abundantly clothed man dreaming of one who is lying in a hammock, wearing only shorts, drinking a cold drink and being cooled by the smile-provoking breezes of a fan.

SAMUEL D. ALLISON, M.D.

Management of Obstetric Difficulties, 6th Ed.

By J. Robert Willson, M.D., M.S., 687 pp., $16.50, The C. V. Mosby Co., 1961.

Formerly by Titus and Willson, this latest edition has been enlarged to include newest methods and many more illustrations. Two chapters (Dystocia due to Developmental Anomalies, and Mutilating Operations on the Fetus) have been eliminated and the information included where the respective subjects occur in the text.

Detailed as it is in all phases of *prevention* as well as *management* of difficulties, I find the chapter on Induction of Labor has not been "brought up to date." I'm certain many will agree that in diabetes and in previously sensitized Rh negative cases, attempts at induction of labor are more and more commonly indicated, and not rarely as the author states.

In addition, newer techniques of regional anesthesia, notably *transvaginal* pudendal block and paracervical block, are conspicuous by their absence.

The chapter on forceps is more clearly illustrated, but the vacuum extractor which has earned wide acceptance in Europe was not mentioned.

In general however, this book is very complete, and continues to deserve its place in every physician's mental file of excellent reference books in the specialty.

ARNO J. MUNDT, M.D.

★ Highly recommended.

★Psychiatry. Vol. 1, Principles.

By E. Eduardo Krapf, M.D., 244 pp., $6.50, Grune & Stratton, Inc., 1961.

The author states that "there exists basically no psychiatric activity, in diagnosis or therapy, which does not require an essentially multidimensional approach," i.e., that one should study patients "simultaneously as a neurologist and as a differential psychologist." This he has done in this book in a systematic and thorough fashion. However, for the neophyte in psychiatry and occasionally even for the experienced psychiatrist, a psychiatric dictionary or glossary close at hand is essential to follow some of the terms and phrases sprinkled liberally throughout. This book is highly recommended for all who are interested in psychiatry not only because of the precise facts and ideas presented, but because it emphasizes psychiatry as a basic and integral part of medicine. No one school of thought in psychiatry is exclusively highlighted.

Y. T. WONG, M.D.

The Cardiac Arrhythmias

By Brendan Phibbs, M.D., 128 pp., $7.50, The C. V. Mosby Co., 1961.

This book describes pictorially the various arrhythmias encountered in practice. General Practitioners may find reading this book quite helpful in understanding arrhythmias. It is written simply and can be read in a few hours. The discussions are limited, particularly in correlating with auscultatory findings. The book does not add further to the many discussions of this subject in other texts.

NOBORU OISHI, M.D.

★Clinical Methods of Neuro-Ophthalmologic Examination, 2d Ed.

By Alfred Kestenbaum, M.D., 577 pp., $16.75, Grune & Stratton, Inc., 1961.

This text is presented in a more readable fashion than the first edition. The book is larger, with better paper and printing. The material is arranged in much the same manner but the whole presentation is more adaptable to interesting reading. It is an exceedingly fine volume with substantial additions covering many new developments over the past ten years.

The text serves its real purpose: to present a review of the clinical methods of ophthalmologic examination that may be helpful in neurologic differential diagnosis. New methods of diagnostic aid in this complex subject are presented in a well-defined, clear-cut manner and should prove of great practical value to the ophthalmologist. It is very satisfying to know we have at our fingertips an edition of this kind to serve us in our time.

H. F. MOFFAT, M.D.

★Traumatic Lesions of Peripheral Vessels

By Carl W. Hughes, M.D., and Warner F. Bowers, M.D., 197 pp., $8.00, Charles C. Thomas, 1961.

I enjoyed Colonel Hughes and Bowers' book. It is well-written, concise, informative and instructive. It

(Continued on page 276)

County Society Reports

Kauai

The regular monthly meeting of the Kauai County Medical Society was called to order by Dr. Cockett, President, on October 3, 1961, at 7:40 P.M. in Lihue, Kauai.

The Treasurer presented his report. The Kauai County Medical Society voted in September, 1961, to contribute $20.00 toward the Diabetic Drive and this has not been forwarded to date. There is also a delayed statement from the Hawaii Medical Association for plane travel for Doctors Cope and Frazer which has not been paid. Following a discussion, it was moved by Dr. Wade and seconded by Dr. Kim that an assessment of $20.00 be made. This was carried.

Dr. Boyden presented the Hawaii Medical Service Association report of the September 18, 1961, meeting. Concerning the preference of the Kauai County Medical Society to have an equal or greater number of medical members on the Board of Directors, this will be brought before the Chairman of the Review Committee of the H.M.S.A. Following this, a discussion of Papanicolaou smears was brought up. Papanicolaou smears are included in the office call fee and not as a laboratory fee. In regard to multiple consultations, the plan pays for one consultation only.

Following the movie "Hidden Congenital Anomalies of the Newborn," the meeting was adjourned at 9:50 P.M.

* * *

The regular meeting of the Kauai County Medical Society was called to order by Dr. Cockett, President, on November 7, 1961, at 7:45 P.M. at the Wilcox Hospital Library in Lihue, Kauai.

Minutes of the previous meeting were read and the following correction by Dr. Boyden was made. The correction was Chairman of the Medical Committee of the Hawaii Medical Service Association and not Chairman of the Review Committee. This was approved and carried.

A letter from Mrs. Edna Blackstad, Executive Secretary of the American Cancer Society, Kauai Branch, which was a report from the cytological laboratory was read. The members were gratified by Mrs. Blackstad's report.

Following a discussion, it was moved by Dr. Wade, seconded and carried that the President will submit a list of three names to the Hawaii Medical Service Association in regard to the Federal Review Committee.

Dr. Boyden spoke on the special individual enrollment plan for people over 65 years of age. Following this, Dr. Boyden read the Hawaii Medical Service Association reports.

There being no further business, the meeting adjourned at 8:45 P.M.

W. W. GOODHUE, M.D.
Secretary

Hawaii

The October 12, 1961, meeting of the Hawaii County Medical Society was held at the Naniloa Hotel. Guests present were Drs. J. Peerman Nesselrod and Walsh.

A letter was read from Dr. Charlotte Kutsunai thanking the Society for the flower wreath sent at the time of Dr. T. Kutsunai's memorial service.

A letter from the Hawaii State Essay chairman informing the Society that the DPI has approved the AAPS Essay Contest for 1962 was also read.

Dr. Bockrath announced that the free polio vaccine is not available at the present time for indigent patients, but will be available. He added that a program for immunization with the oral polio vaccine is being deferred until organization to immunize as many persons as possible is set up.

Dr. Nesselrod gave the first in a series of two lectures on "Diagnostic Procedures in Proctology, Proctology in Preventative Medicine, and Anal Infections."

* * *

The October 13, 1961 meeting was held at the Hilo Hotel. Guests present were Dr. Nesselrod and HMSA representatives Albert Yuen and Paul Tallett.

Mr. Albert Yuen, HMSA representative, informed the membership of the new surgical fee schedule based on 4.5 relative value. He also discussed fee income ceilings. After a short discussion Dr. Loo moved, Dr. Crawford seconded, that we approve the adoption of the 4.5 relative value schedule as proposed by the HMSA. The motion was carried unanimously.

Dr. Nesselrod then continued the second and last lecture on various phases of proctology.

FRANCIS F. C. WONG, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met Tuesday, October 3, 1961, in the Mabel Smyth Auditorium.

Dr. O. D. Pinkerton discussed the OASI program and who is responsible for payment of filling out claim forms for disability benefits under this program, namely the patient. A film entitled "Disability Decision" obtained from the local Social Security office was shown. A discussion followed with Mr. Harold S. Burr, district manager; Edwin Ichiyama; and Dr. S. R. Horio, present to answer questions.

Dr. Michael M. Okihiro presented a talk on "Some Common Neurologic Entities which are Amenable to Treatment."

The chair announced that Dr. Moore's letter of resignation was read at the last membership meeting, however, was not circulated, and that Dr. Moore's resignation as Secretary of the Society was the reason for his name not appearing on the Nominating Committee's report.

Dr. Ando announced that the Hawaii Physicians League for Good Government is planning a political action course co-sponsored by the Chamber of Commerce. All doctors were urged to enroll for this course.

Dr. Sloan announced that an invitation and brochure were being mailed out to all physicians in the State to attend a lecture series by Dr. J. Peerman Nesselrod presented through the courtesy of the Hawaii Academy of General Practice and made possible by a grant from Eli Lilly Company. Dr. Sloan urged all the doctors to attend.

The chair announced that Dr. Richard K. C. Lee has written a letter thanking the Society for its help and participation in the Pacific Science Congress held here recently.

(Continued on page 266)

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

November 8, 1961, at 6:30 P.M.
Oahu Country Club, Honolulu

PRESENT

Dr. J. A. Burden, presiding; Drs. Allison, Andrews, Benson, Cushnie, Goodhue, Miyamoto (for Dr. Bergin), Nishijima, Richert. and West plus Drs. Arnold, Liljestrand, and Yamauchi, Mr. Howard Pearce, and Mr. Hugh Lytle.

MINUTES

The minutes of the July 21, 1961, meeting were approved as published.

PROPOSED VISIT OF DR. EDWARD ANNIS

Dr. Burden felt that Dr. Annis's visit would be most worth while but questioned if his capabilities could be fully used in the short visit proposed. Upon Dr. Burden's return from the mainland, he sent a letter to Dr. Annis expressing the hope that he would be able to come at a future date and plans for the November visit were dropped. The cost of Dr. Annis's visit was discussed. It was suggested that if the other counties were willing to assume the cost of his expenses on their islands, Honolulu should assume his expenses on Oahu so that the cost to any individual society would not be too great. The HMA would assume the cost of bringing him to Hawaii.

ACTION:

It was moved, seconded, and passed that the HMA go ahead with the negotiations to bring Dr. Annis to Hawaii and determine how his trip can be financed by all the counties and the HMA combined.

MEDICARE SUPPLEMENTAL AGREEMENT

Dr. Nishijima outlined the reasons for the Federal Medical Services Committee's decision not to sign the ODMC agreement stipulating that in the future Medicare fee schedules could not be published. No action was taken.

RECRUITMENT OF PHYSIATRIST

Dr. Burden read a letter from the Oahu Health Council asking for HMA support in recruiting a physician to take advanced training in physical medicine. Suggestions for recruitment included notifying the training hospitals, the county societies, and putting a notice in the Newsletter.

ACTION:

It was moved, seconded, and passed that the HMA cooperate in furthering the desires of the Oahu Health Council in recruiting a physiatrist.

SECRETARY'S REPORT

Dr. West advised that the following changes have been made to the roster: Additions—July [Hawaii], Wilmot Boone; August [Honolulu], Royal DeLany, Ira Hirschy, Henry H. L. Yim, John Fairchild (associate); September [Honolulu], Anna Maria Brault, Walter Chang, Keith Kuhlman, Richard Mamiya, Michael Oki-

(Continued on page 268)

AMA Delegate's Report

The 15th clinical meeting of the AMA was held in Denver from November 26 to 30. Two hundred fourteen delegates met in the Denver-Hilton Hotel. Among other actions, they

"Heartily approved" of AMPAC, the newly created American Medical Political Action Committee, to which doctors, their wives, and their interested neighbors are urged to contribute support and money, to help stop Social Security medicine and to help elect congressmen who will oppose galloping socialism.

Censured the American College of Surgeons, by endorsing the intent of five resolutions to this general effect, for creating a public impression that they, rather than the AMA, were defending the public against improper surgical practices, and approved a planned meeting between the AMA trustees and the College Regents to discuss it.

Approved a special committee to look into the methods of the Joint Commission on Accreditation of Hospitals, because of widespread dissatisfaction with the Commission.

Re-referred to the Council an amendment which would have legalized the Judicial Council's right to original jurisdiction in disciplinary cases, accorded it last June.

Approved a merger between AMEF (the American Medical Education Foundation) and AMRF (the American Medical Research Foundation) into the American Medical Association Education and Research Foundation (AMA-ERF), effective January 1, 1962. Neither foundation's program will be curtailed by the merger.

Endorsed operation of indigent medical care plans by the state and local health departments if Blue Shield or medical society agencies seem undesirable at the local level.

Agreed that public assistance programs should be based on need, not on age, disabilities, or other criteria.

Amended the Constitution and Bylaws to provide for succession of the President-elect and Vice President to the Presidency.

Rejected a proposed amendment requiring resolutions to be introduced either 45 or 30 days in advance of each session.

Recognized that Louisiana is now alone among the states in denying medical society membership to Negro physicians.

Chose Miami for the 1964 winter meeting.

Commended Dr. Blasingame and his staff for efficiency.

(Continued on page 268)

Notes and News

Names in the News

Dr. Mourice de Horne was the object of the headline "Surfer Saves Medic Mile at Sea" recently when his sailboat capsized.

Dr. Robert A. Nordyke discussed nuclear medicine at the luncheon meeting of the Rotary Club.

Dr. Howord Liljestrond relinquished the chair of the Hospital Association of Hawaii, and created quite a stir with his advanced "look" at modern medicine, satellite hospitals, etc.

Forecast of a breakthrough in cancer treatment in a year by Dr. I. S. Ravdin of Philadelphia caused many comments locally. **Drs. F. J. Pinkerton, I. L. Tilden, Walter Quisenberry,** and **Horold Civin** made pertinent remarks for publication.

Dr. Richard K. C. Lee was elected Vice President of the American Public Health Association at its meeting in Detroit.

Dr. J. C. Milnor spoke to members of the Hawaiian Association to Help Retarded Children.

Dr. Samuel L. Yee resigned as director of the Garden Isle Hotel. **Dr. Richard You** still remains as director. Dr. You also was honored by being elected Secretary of the U. S. Olympic Games Committee for Weightlifting.

Dr. Lucy Mo Fong bought a show place home on Diamond Head Circle for $290,000. Whew!!!

City Medical Examiner **Dr. A. V. Majosko** announced that every third driver involved in fatal auto accidents had alcohol (blood) content of 1.5% or better.

The medical plan for the Kauai County pensioners was held illegal. County government physician, **Dr. Peter Kim,** was named the only authorized doctor to whom pensioners could go for treatment.

Dr. V. G. Boido of Kauai received some unhappy news recently when a story of his mother's passing was headlined in the local newspapers.

Wives of physicians frequently enhance the public image of their husbands. Recently Jean Mason, wife of **Dr. Corl B. Moson,** was prominently featured for her great conquest of the crippling effects of polio. She was complimented in a deserving manner. Tetta Richert, wife of **Dr. Thomos H. Richert,** was also featured recently for her skills in her hobbies, autoracing and skindiving. Lois Lucas, wife of **Dr. Joseph T. Lucas** and President of Honolulu's Woman's Auxiliary, greeted the President of the Woman's Auxiliary of the AMA and was featured in the local press, as were the various social and business events attending the presence of a mainland dignitary.

Drs. Fred L. Giles, Edward W. Boone, and **Robert A. Nordyke** ably presented a "Medical Aspects of Nuclear Explosion over Oahu" on KONA-TV recently.

Nine offices (eight physicians) at the Medical Arts Bldg. were broken into recently. Suffering losses were **Drs. George Goto, Clorence Sugiharo, Thomos Oshiro, Wolloce Kowaoko, Ichiro Nadomoto, Edword Emuro, Nobuyuki Nokasone,** and **Richord Ando.**

Dr. Teru Togosoki, President of the Honolulu League of Women Voters, was instrumental in an attempt to establish a branch of the organization in Windward Oahu.

FRANK E. GLASER, M.D.
1909-1961

Dr. Frank Eugene Glaser died suddenly of acute coronary occlusion, at 11:30 P.M., November 4, 1961.

He was born October 2, 1909; received his degree of B.S. from the University of Wisconsin in 1933, and his M.D. from the same school in 1950. In the interval, he worked as a lithograph artist in Madison, Wisconsin, until entering the Army in 1943.

Following internships at the University Hospital, Iowa City, and at St. Francis Hospital, Honolulu, he served as Staff Physician at the Southshore (now Leeward) Hospital until 1952. After a month's service on Wake Island, he served a residency in psychiatry at the Veterans Administration Hospital, Sawtelle, California, and the Pacific State Hospital, Spadra, California, returning to Southshore Hospital where he worked until 1958.

In May, 1958, he joined the Hawaii Department of Health as assistant chief, Bureaus of Geriatrics, Cancer Control, and Venereal Disease Control (now Adult Health Branch). His special duties were concerned with heart disease control, rehabilitation, and venereal disease, but he soon began to help in the Alcoholism Clinic. He was also largely instrumental in developing the first glaucoma clinic, conducted by the Lions Clubs and the Bureau of Sight Conservation.

In 1959, he returned to the mainland for a year at the University of California School of Public Health, receiving the degree of M.P.H. in 1960. Back in Hawaii, he was made Chief of the newly created Bureau of Alcoholism (now Alcoholism Branch), in which position he was active until his death. He was one of the chief developers of the Halfway House for alcoholics on Sand Island, and at the time of his death was seeking ways to make the project permanent. He was a charter member of the Board of Trustees of the Hawaii Alcoholism Foundation, and a director of the Hawaii Committee on Alcoholism.

He is survived by his wife, the former Nadine Cabell Whitener; a step-daughter, Mrs. Karen Miller Turpin; a son, George Finley, aged 6, and a daughter, Gretchen Ruth, aged 2; also his father, Gustav George Glaser, and a sister, Mrs. Norma Sawyer.

He was particularly well fitted, by experience, interest, and ability, for the conduct of the Alcoholism program, and it will be most difficult to replace him. We who knew him well, enjoyed his friendly personality, and observed his devotion to his chosen field, will miss him greatly.

NORMAN R. SLOAN, M.D.

The annual Diabetes Detection Week got off to its usual good start this year under the chairmanship of **Dr. Donald W. Brown.**

Maui Doctors **Frank A. St. Sure** and **William E. Iaconnetti** were members of a committee to study problems of the Hana Hospital. **Dr. Sumner Price** has found that Maui should abandon the hospital and replace it with a modern health center.

Dr. Robert Chung was much in the news at the groundbreaking ceremonies of the Windward Hospital, also when a military jet crashed into houses. He was very critical of the lack of supervision of emergency units.

Tomi Knaefler's report in the *Star-Bulletin* on "Poll of Doctors on Home Calls" got varied responses from **Drs. Mills, Felix, Gilbert, Chu, Goto, Larsen,** and **Moore.**

Dr. Ralph Bingham Cloward set things straight when he was credited for comments of his "pop," **Dr. R. E. Cloward.**

Senate sub-committee hearings on the medical aid for the aged recently conducted by Senators Oren Long and Wayne Morse caused quite a stir in the community. Some of the participants (medical) who gave a creditable account of themselves and the profession were **Drs. J. A. Burden, Shoyei Yamauchi,** and **Philip Chu** in Honolulu; **Dr. Webster Boyden** on Kauai; and **Dr. Joseph E. Andrews** on Maui.

Congratulations!

to Grandpa (first time) **Dr. Joe Palma,** whose daughter Joan gave birth to a son in San Francisco.

to **Dr. Bob Faus** for the Pfizer award for his contributions to medical health and disaster preparedness.

to **Dr. I. L. Tilden,** second time president of the Hawaii Division, American Cancer Society. Also to **Drs. Grover Batten** and **James Mitchel,** vice presidents; **Carl Mason, Walter Quisenberry,** and **Samuel Allison,** board members.

to **Dr. A. Ng Kamsat,** new president of the Mun Lun School. He succeeds **Dr. David Pang.**

to **Dr. Ed B. Helms** of Hilo, new president of the Hawaii Association of Plantation Physicians. **Dr. Patrick Cockett** of Kauai preceded him.

to **Dr. John Felix,** recently elected president of the Hawaii Academy of General Practice.

to **Dr. John Lowrey,** the new head of the Hawaii chapter of the American College of Surgeons. **Dr. L. Q. Pang** is the vice president.

to **Dr. Clarence Trexler,** who was elected president of the Pacific Coast Oto-Ophthalmological Society at a recent California meeting.

to all the new county medical society presidents: **Drs. Pete Okumoto,** Hawaii; **Ogden Pinkerton,** Honolulu; **Marvin Brennecke,** Kauai; and **Clifford Moran,** Maui.

TOSHIO KUTSUNAI, M.D.
1901 - 1961

Dr. Toshio Kutsunai died at The Queen's Hospital on September 30, 1961, after a lengthy illness. Even while he was hospitalized, he continued to do as much as possible for his patients, and he carried on daily correspondence with his office staff up until the day of his death. Because of his failing health he had long attempted to restrict his practice entirely to ophthalmology, but his patients continued to return for every type of illness that befalls mankind.

Dr. Kutsunai was born in Kohala on August 16, 1901, the son of Tomezu and Mine Kutsunai. He was educated at McKinley High School, the University of Hawaii and Northwestern University Medical School. He interned at Nebraska Methodist Hospital in Omaha, and Cook County Hospital in Chicago, where he also served as a resident in pathology.

He returned to his birthplace, Kohala, to practice medicine, and his skill and fame spread rapidly throughout the entire Island of Hawaii. Since so many thousands of patients made the long trek from Hilo to Kohala, he was persuaded to practice in Hilo. He operated the Kutsunai Hospital at Papaikou, Hawaii, until 1941.

He married Kinuko Kunimoto, who survives him. He is also survived by his daughter, Charlotte T. Kutsunai, M.D., who at-present is a resident in anesthesiology in Los Angeles, and two sisters, Mrs. James Yabusaki of Hilo and Mrs. Taro Suzuki of Honolulu.

In late 1941, he decided to do further postgraduate work at the University of Pennsylvania Graduate School of Medicine in ophthalmology, the field of medicine which fascinated him the most. Following the completion of his studies there, he continued his studies at Harvard University Medical School, Tufts Medical School, and the Cook County Hospital in Chicago.

He was a diplomate of the National Board of the American Board of Ophthalmology, and a member of the American Medical Association, the American Academy of Ophthalmology-Otolaryngology, the American Association for the Advancement of Science, and the New York Academy of Sciences. In addition, he was Chief of Staff of Hilo Memorial Hospital for several years and a past president of the Hawaii County Medical Society.

Upon his return in 1945 from doing graduate work he opened his office at 272 Kinoole Street, Hilo, Hawaii, and practiced there until his death. During his lifetime of medical work, he built one of the largest practices in Hawaii, and he also gained the respect and admiration from his colleagues. Doctors in his community relied upon him for his vast knowledge and keen judgment and often consulted him for their patients as well as for themselves.

His tireless devotion to his patients and his continuous scholarly research earned him the love and reverence from the people, unheard of in this day and age.

In spite of his many lingering ailments he pursued various fields of studies. His linguistic proficiency enabled him to peruse German, French, and Japanese medical literature.

Dr. Kutsunai was a profound scholar, a dedicated doctor, and a great and humble man. His philosophical and religious attitude toward life sustained him throughout his career and provided comfort, security and wisdom to all who had known him until his dying day.

SAMUEL M. HARAGUCHI, M.D.

New Locations and Affiliations

The "safari" to 1441 Kapiolani continues. New tenants are **Drs. Harold F. Moffot, Frances Cottington, Sylvio Hoven, Albert K. S. Chun, Cesor B. De Jesus, Joseph C. Finney, George W. Henry, Carl B. Moson,** and **Drs. Moore** and **Arthur.**

Dr. Hermon P. Kromer has opened an office in Waimanalo.

Dr. Virginio Zimmermonn became associated with **Dr. Edmund Lee** in the general practice of medicine at the Professional Center Building.

Drs. Donald T. Smith and **John Stephenson** announced their affiliation with the Straub Clinic.

Dr. Benjamin C. K. Tom has located at the Continental Medical Building, 1531 So. Beretania.

Drs. Edmund C. K. Lum, orthopedist, and **Chorles K. Yomoshiro,** ob-gyn, opened branch offices in the Kaneohe Medical Building.

Travel News

Dr. Kozuo Miyamoto recently went to Okinawa as a Consultant in General Practice to the Surgeon General of the U. S. Air Force. He also presented a paper at the Pacific Air Force Medical Meeting at Baguio, P. I., and attended a two-day course of Consultants to the Surgeon General at the Ohio State Medical School.

Dr. C. E. Fronk also attended the Baguio meeting. He noted great progress in the Filipino people.

Dr. Thomos Chong spent two weeks seeing the Far East sights with his good friend, actor Benson Fong.

Drs. Clorence W. Trexler and **John P. Frozer** attended the American Academy of Ophthalmology and Otolaryngology meeting in Chicago.

Dr. Horry L. Arnold, Jr. attended the AMA meeting in Denver and the American Academy of Dermatology meeting in Chicago, in December.

Dr. Bloine S. Boyden announced his association with Drs. Pischel and Colyear of San Francisco.

Dr. Edword Boone was one of 18 physicians who attended a four-day course in mass casualty management at Brooke Army Medical Center in Texas.

Hawaii Doctors in Print

Dr. Robert T. S. Jim wrote an article on "Quantitative Determination of A2 Hemoglobin by Paper Electrophoresis Using Tris Buffer" which appeared in the July, 1961, issue of the *Journal of Clinical Pathology.* **Dr. Joseph Polmo's** article on "Medicine is a Life Service" appeared in the December 9 issue of *JAMA.*

Obituary

Dr. Fronk E. Glaser, Director of the State's Alcoholism Clinic, passed away unexpectedly. He had been with the Health Department since 1955. Dr. Richard K. C. Lee said, "Dr. Glaser pioneered in a new and difficult field of public health. His leadership and knowledge of the problems will be sorely missed."

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1. Sollmann, T.: A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology, ed. 8, Philadelphia, W. B. Saunders Company, 1957, p. 206.

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

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President's Message

Dear Friends:

After many years of close and warm association with the HAWAII MEDICAL JOURNAL, the INTER-ISLAND NURSES' BULLETIN regretfully terminates its joint publication as of this issue. This decision was made after much deliberation by the members of the Hawaii Nurses Association.

The members of HNA wish to express their sincerest appreciation for the privilege of partnership accorded them and particularly to the editorial staff of the BULLETIN for their inspiration and cooperation over the years.

We wish to assure all that we will continue to support the HAWAII MEDICAL JOURNAL to the best of our abilities.

Sincerely,

KAZUE MCLAREN, *President*
Hawaii Nurses Association

General Interest

30th Annual Meeting

The 30th annual convention of the Hawaii Nurses' Association with three days of meetings and events was successful, if we use the tabulated evaluations as a criteria.

The President Speaks—The opening address of the HNA president challenged the nurses to greater individual and group participation and challenged them to a membership of 1000 in their association.

ANA Director—"What's ahead for Nursing" by Mrs. Olive Klump showed how ideas, ideals, and goals have been enunciated and translated into action during the six and one-half decades of the existence of the ANA.

Reference to the report of the committee on Current and Long-Term Goals was reviewed. This is an area where all of us should strive to become more informed. This decade will be one of many changes, planned changes, and one of many accomplishments. "We are not suffering growing pains; we have the professional and social maturity to consider our problems objectively, set our goals, and plan the necessary actions for achieving them."

"Our Changing National Economy"—"Interesting," "informative," "full of food for thought," and "stimulating" are only a few of the adjectives used to describe the talk by Dean Michael Wermel.

Reaction Panels—The response of the membership to the excellent resource people on our reaction panels is most gratifying. Participation of this nature gives you a voice in your association activities.

Election returns, introduction of the new HNA Board, and receiving of leis finalized the meeting.

Tapes of Dean Wermel's and Dean Jones's speeches are in the headquarters office. Papers of Dean Jones and Mrs. Klump in detail are also available. If you wish to use these for meetings, please let us hear from you.

A Profile of the Nurse of Tomorrow*

I accepted this assignment because I felt no one could take issue with me since no one is sure what the nurses of tomorrow may need to be. Since we in nursing have not yet caught up with today—tomorrow is really today. I should like to talk about some things which I believe are crucial in nursing today and tomorrow if nursing is to meet society's needs—as those needs change. Unless it does meet society's needs, it will not be a profession, indeed if it does not meet those needs it may not exist at all.

I am starting out with certain assumptions to which I hope we all agree:

1. The nurse we are talking about is what we have called the "professional nurse."
2. Nursing must meet certain unique, definite, and social functions in order to be a profession and those functions can be identified.
3. Functions of the nurse change as society's needs and forces change.
4. Nurses want nursing to become a profession.

Hospital statistics alone tell us that fewer patients need prolonged or even short-term physical nursing care. Immunizations, new drugs, daring surgical interventions, fantastic mechanical aids, and developing rehabilitation measures will make the number of such patients even smaller. This is true even in the aging group. There is now a movement to isolate even this relatively small number into intensive care units so that only a certain few nurses will give the acute care needed. The greater number of nurses will be caring for patients who are able to meet their own daily physical care needs in their own usual way and should be encouraged to do so. We shall need an entirely new set of criteria for judging good nursing care.

The hospital is becoming more and more a place for people to come for preventive measures, periodic physical examinations, and routine tests. People who come for these services are well, independently-functioning individuals as they enter the hospital. Do we treat them as such when they are admitted? Too often they must be put into hospital clothing, stay in bed, eat from a tray and use appliances meant for the bedfast. Certainly this does not give the man who is conscientiously trying to keep well a sense of well-being which the periodic examination is meant to maintain. The nurse must see these people as a busy wage-earner or a harried mother taking time out of a busy day to carry out activities which we advocate to keep well.

As care moves more and more out of the hospital we realize the need for continuity of care from home to hospital, from hospital to home, to community.

Another change in patient care is the introduction of multifarious workers in the patient care program to all of which the patient and the nurse herself must relate. At the same time, fewer physicians have less time for more patients. Who is going to see the patient as a person receiving service from and reacting to all of these individuals each of which comes, performs his special service, and departs? How is the nurse to find her role in this complex service? What is her function? Has the so-

* Excerpts from the paper read at the 30th Annual Meeting, November 30, 1961, of the Hawaii Nurses Association.

called nursing team plan met this problem? I thought I was being original when I say I believe that the professional nurse should be the one person responsible for planning all care the patient receives in terms of the therapeutic program and his own personal needs, including that of specialists such as laboratory workers, dietitians, therapists, and the like. But lo and behold I find this in the 1961 *Psychodynamic Nursing*, by Brown and Fowler.

We have said that the nurse should be the expert practitioner responsible for all the patient's care under the sole direction of the physician. This involves the nurse's determining care needs, making a plan for meeting these needs, and implementing the plan with whatever team members are needed.

Lesnik has made attempts to clarify the functions and prerogatives of the professional nurse that are supported legally. One of these "independent legal functions" which he describes "is observation of symptoms and reactions including the limited responsibility of diagnosis without the right to prescribe treatment or medication, and limited by the individual nurses's background, training and experience." McManus makes further clarification of this function by saying: "The function of the professional nurse is conceived to parallel somewhat that of the professional physician. The unique responsibility of the physician recognized by law is to identify the medical problem, diagnose, and plan and prescribe treatment. . . . Similarly, the unique function of the professional nurse may be conceived to be: (1) the identification or diagnosis of the nursing problem and the recognition of its interrelated aspects; (2) the deciding upon a course of nursing action to be followed for the solution of the problem, in light of immediate and long-term objectives of nursing, with regard to prevention of illness, direct care, rehabilitation, and promotion of the highest standard of health possible for the individual."

Abdellah calls this function "making a nursing diagnosis" which she defines as "a determination of the nature and extent of nursing problems presented by individual patients and families receiving nursing care.

This term "nursing diagnosis" is a new and terrifying term to us because of its connotation of medical practice.

The uniqueness of the nurse's function lies in her day-by-day contact with the patient and the people and things that concern him. This is true whether he be bedfast or convalescing. Because of this contact she can perform as a therapist in a way that no other team member can. This uniqueness has its roots in patient-centered care. By means of this kind of contact the nurse gathers information which the doctor uses to make his diagnosis. Her continuous observation will make it possible for her to identify less visible as well as highly visible problems which affect the patient's recovery. With her understanding of patient's problems she can create an environment which meets his individual needs. The information which she gathers, the analysis she makes and the evaluation of her findings, become the basis for research. This research provides a scientific basis for improving patient care, a body of knowledge unique to nursing.

It has been said and with reason, that the nurse was first a technician, is becoming an expert practitioner and must in the future be a therapist. As a technician she is required to be able to carry out procedures in the way that she has been taught and carry on other activities with little responsibility for analysis of principles or for effecting change for improvement. As an expert practitioner she has knowledge of patient conditions, of the principles from the physical and social sciences upon which to base her care and uses these understandings expertly in planning for and giving care. As a therapist, in addition to the abilities needed for observing patient problems, carrying out necessary care, the nurse must analyze the care that patients get in terms of their needs and be able to effect changes to provide the therapeutic care needed by each individual patient. If nursing wishes to preserve this uniqueness and with it the identity of nursing it must as Abdellah points out, "critically analyze every single function, procedure and routine in the whole range of nursing practice in terms of meeting patient's needs and must make changes as indicated.

It seems to me that this implies several things: (1) every nurse must learn that change is inevitable, (2) that each nurse must accept her role as a change agent, i.e., as a person who can evaluate and manipulate change so that it contributes to her unique function of patient-centered care, (3) that the nurse's function is to make nursing diagnoses and plan and give or be responsible for individual nursing care based on this diagnosis, (4) that nurses must initiate and effect changes which make the best kind of patient-centered care possible, (5) that to do these things the nurse must have a sound scientific foundation, a broad liberal arts background to understand people, and the forces which motivate their behavior, an ability to identify and approach problems scientifically using these backgrounds and certainly she must have the courage to put her findings into practice. What these practices shall be can only be determined through identifying the problems, applying the available principles and information and then trying out and evaluating various solutions always in terms of meeting patient needs.

I can hear the agency personnel in the audience saying, "Well, this is a job for the nursing educators." I am sure those in nursing education are saying, "We can teach this kind of nursing care to students but the climate is often such that they can't practice it as staff nurses"—so it seems that the kind of nurse we have for tomorrow will depend upon whether the service personnel and the nursing educators can agree on the kind of patient care they want to demand and then work together in teaching and in practice to accomplish it. It's later than you think.

This is needed TODAY.

VIRGINIA A. JONES, R.N.

Senate Special Committee on Aging

Senator Oren E. Long, assisted by Senator Wayne Morse of Oregon, presided at four field hearings of a Subcommittee of the Senate Special Committee on Aging which were held in Honolulu, November 27; Lihue, November 29; Wailuku, November 30; and Hilo, December 1.

The hearings covered Federal and State activities in the field of aging. State officials, organizational representatives, and senior citizens themselves were invited to testify.

In announcing the hearings, Senator Long said: "Too often, as a result of our distance from the mainland, Hawaii is overlooked when the problems of older citizens are explored. Our older people have their problems, too. While our population over 65 is still small in numbers, it is growing at a much faster rate than is the aged population nationally. Attention to our older people now can mean that Hawaii's problems of aging do not become so acute as they are elsewhere in the nation. We feel also that Hawaii has a rich family culture that provides special values for older people and we would therefore like to share this information with our fellow Americans. For these reasons, I am happy to announce that four of our Island communities will be among the thirty-two cities in which hearings are being held by the Senate's Special Committee on Aging."

The sessions included testimony from Hawaii officials in charge of programs affecting older citizens, from spokesmen of organized groups of senior citizens, and from University and other people particularly knowledgeable in the field of aging.

In the afternoon in Honolulu and in the latter parts of sessions in the Neighbor Islands, Senator Long heard testimony of individual citizens themselves. "In these town-hall meetings, where we have an opportunity to talk with our older people and to learn firsthand of their problems, lies the unique value of our hearings," said Senator Long. "We are, of course, interested in the testimony of the experts, but we are especially anxious to hear older people, their children and their friends speak for themselves. They can tell us what their problems are and what they think can be done about them. Therefore, I am extending a cordial invitation to Hawaii's people to attend these 'Town Meetings of Senior Citizens' and to get their stories in the official record of the United States Senate," Senator Long concluded.

The testimony entered by the organizations represented at the hearing emphasized the political aspects of health care for the aged. The AFofL and ILWU speakers took a firm stand favoring the King-Anderson bill, while most of the non-union leaders presented an equally strong stand opposing this type legislation. The senior citizens themselves were interested mostly in tax relief and work opportunities.

The Peace Corps

The ANA has been kept informed about the Peace Corps since its inception in March, 1961. At various intervals communications have been sent to Mr. R. Sargent Shriver, Director of the Peace Corps, and to members of his staff, expressing interest in Peace Corps projects which relate to nurses, nursing, and health. Since the Peace Corps is now an official agency (September 30, 1961), we wish to share the information with you.

At a recent Peace Corps Conference in New York City, it was explained that the function of these volunteers is to provide "middle manpower" for underdeveloped countries which request this kind of assistance. In other words, nurses with the Peace Corps do not serve as consultants or as directors of health agencies or nursing school programs but actually work on the wards of hospitals, as instructors on nursing school faculties, in public health clinics, and as health educators. For example, a current Peace Corps project which is being developed for a South American country will include two professional nurses who will work in cooperation with a local government health center, in clinics and in health education, including the teaching of home nursing.

The American Nurses' Association has urged the Peace Corps to obtain assistance from a qualified professional nurse in regard to questions related to assignment, selection, and training of nurses. They have been referred to Miss Julia Thompson, R.N., ANA Assistant Executive Secretary, Washington office, the nursing staffs of the Agency for International Development (formerly the International Cooperation Administration), the regional office of the World Health Organization, and the United States Public Health Service. Attention also has been called to the assistance which can be provided by the Professional Coun-

seling and Placement Service through supplying professional biographies of nurses applying to the Peace Corps. It is our understanding that several hundred nurses have applied to the Peace Corps so far. A number of nurses have completed training in this country and are already overseas—in Chile and in Pakistan; others are in training for a project in Malaya. When there is opportunity to communicate with a nurse volunteer, her attention is called to the direct active ANA membership which is open to nurses residing in foreign countries and, if she is an ANA member, the International Unit can provide her with a card of introduction to the national nurses association. The Peace Corps apparently has received a number of requests for development of projects in the health field, and there is increasing indication that the professional association may be called upon to assist with recruitment of qualified nurse volunteers. It is the belief of the American Nurses' Association that its effort in this regard should be similar to that put forth on behalf of other Federal agencies, for example, the military Nurse Corps. In other words, it will call this need to the attention of state nurses associations, and will include information about the Peace Corps in answers to inquiries from nurses interested in experience in other countries.

Nursing Excellence— ANA Convention Focus

May 14-18 are the dates—Detroit is the place —"Excellence in Nursing—Progress in Health" is the theme!

ANA's 43rd convention will emphasize the importance of good nursing to man's health future, and will feature programs and clinical sessions geared to the improvement of nursing practice.

Detroit's $54 million Civic Center will be the site of the 1962 ANA Convention and Clinical Sessions. The House of Delegates and the general program meetings will be held in the rotunda Convention Arena; connecting Cobo Hall will house the exhibits and provide space for registration. Meeting rooms will be on the top level. The Public Health Banquet (open to all attending the convention) will be held in the banquet hall overlooking the Detroit River.

The ANA convention flyer and hotel reservation form will be sent to each member in January. Plan now to attend so that you can send the flyer back early. This promises to be a most stimulating, rewarding convention.

Clinical Sessions to Offer Variety

Clinical sessions being planned for the 1962 ANA Convention will offer nurses an opportunity to keep abreast of the latest advances in nursing knowledge. Twenty sessions will be held simultaneously on Tuesday afternoon, May 15, and Thursday morning, May 17. Subjects already have been selected for five of the sessions. A program on "Technical Innovations in Health Care: Nursing Implications" will highlight the nursing care of patients who have had open heart surgery, chemotherapy for cancer, and other recently developed treatments.

"Nursing in Relation to the Impact of Illness Upon the Family" will be the subject of a program showing ways in which the nurse can support the family of the child with leukemia and how she can facilitate family acceptance of the patient who has had disfiguring surgery.

A program on "Emergency Intervention by the Nurse" will center on examples of emergency measures appropriate to nurses, such as actions which reduce patient anxiety, nursing actions to be taken during hemorrhage of the patient, etc.

A program revolving around new concepts of nurse-patient relationships and their effects upon nursing care will be presented by the nurses who have initiated and tested the relationships. "Nursing Care of the Patient with Burns" will be the topic of a program presenting an intensive study of how nurses are able to meet the needs of a child with extensive burns.

Tentative plans have been made for the remaining fifteen clinical sessions. There will be an exploration of problems in nursing common to all areas of practice, presentations which show the situations in which problems occur, and methods by which the nurse handles them. At least two sessions are expected to deal with understanding different phases in human development and its relevance in nursing care.

Time for a Change? See AJN Article

What should ANA be doing as the professional association of registered nurses? How can it best help you?

A search for answers to these questions is being undertaken by the Study Committee on the Functions of ANA. Progress of the committee, as reported in the November *American Journal of Nursing* ("Is It Time for a Change?") should be of vital interest and concern to all ANA members. Reprints are available from ANA at 15¢ each.

One major objective of the committee is to advise ways and means by which ANA can better meet clinical interest of nurses.

Since this question is one of special interest to all ANA members, you may wish to study the *AJN* article and pass along your reactions to your district and state nurses associations.

Although Study Committee reports have, to date, been progress reports, it is anticipated that specific recommendations for some organizational rearrangements can be presented to the House of Delegates at the May, 1962, Convention for study by the membership in the ensuing two years.

Foundation Begins Its Expanded Program

The funds secured thus far in the American Nurses' Foundation Drive for at least $1 million (to expand its program of nursing research) have enabled the ANF to begin parts of its expanded program.

The first research grant has been awarded to Rancho Los Amigos Hospital in Downey, California, for a year's study of nursing in relation to the rehabilitation of incontinent elderly patients.

Research consultant services have begun with the appointment of Dr. Myrthle Irene Brown, who will travel across the country to discuss research findings and to guide nurse leaders in research projects.

The first monograph made possible by campaign funds appeared in August. It is a report by the Boston University Human Relations Center staff on an outpatient nursing study which started under an ANF grant.

The Foundation is beginning a service for abstracting reports of nursing research. ANF staff will report at workshops in Indiana and Michigan in October on the public health nursing study of ANF. A report on its cardiac convention of the American Heart Association at Miami Beach in October.

Head Nurse Committee Adopts Eight Goals

ANA-sponsored workshops for head nurses is a future goal developed by the Committee on FS&Q for Practice of the Head Nurses Branch, ANA General Duty Nurses Section. At its June, 1961, meeting, the committee decided that both immediate and future goals should be developed.

Immediate goals include: (1) Preparation of a bibliography on counseling and guidance, evaluation, interpersonal relationships, and staffing. (2) Preparation of materials for *ANA In Review* and the *American Journal of Nursing* which will be helpful to head nurses in meeting day-to-day problems. (3) Guidance for the administration and content of SNA and DNA section workshops. (4) Development of a report (to be presented at the 1962 convention) which will be meaningful to branch members.

Future goals are: (1) ANA-sponsored workshops for head nurses. (2) Review and analysis of material relating to functions from survey on head nurse positions. (3) Articles for the *AJN* written by head nurses. (4) Preparation of materials which would help head nurses interpret and make use of the statements of FS&Q.

Opportunities in the Armed Forces

The Army Medical Service has an immediate need for 500 additional nurses and the Air Force for approximately 22.

The need for more nurses to maintain the medical care program was stressed by Lieutenant General Leonard D. Heaton, Army Surgeon General, who said, "Expansion of the Army and stepped up training means more soldier patients. The strength of the Army Nurse Corps must keep pace."

The Army hopes to meet immediate requirements through volunteer nurses, mainly young women and men who have not yet served in the Armed Forces, thus avoiding a serious disruption of civilian and government hospitals.

The greatest need is for general duty nurses, General Heaton pointed out, but critical requirements also exist for qualified individuals in the clinical fields of operating room, anesthesia, and neuropsychiatry.

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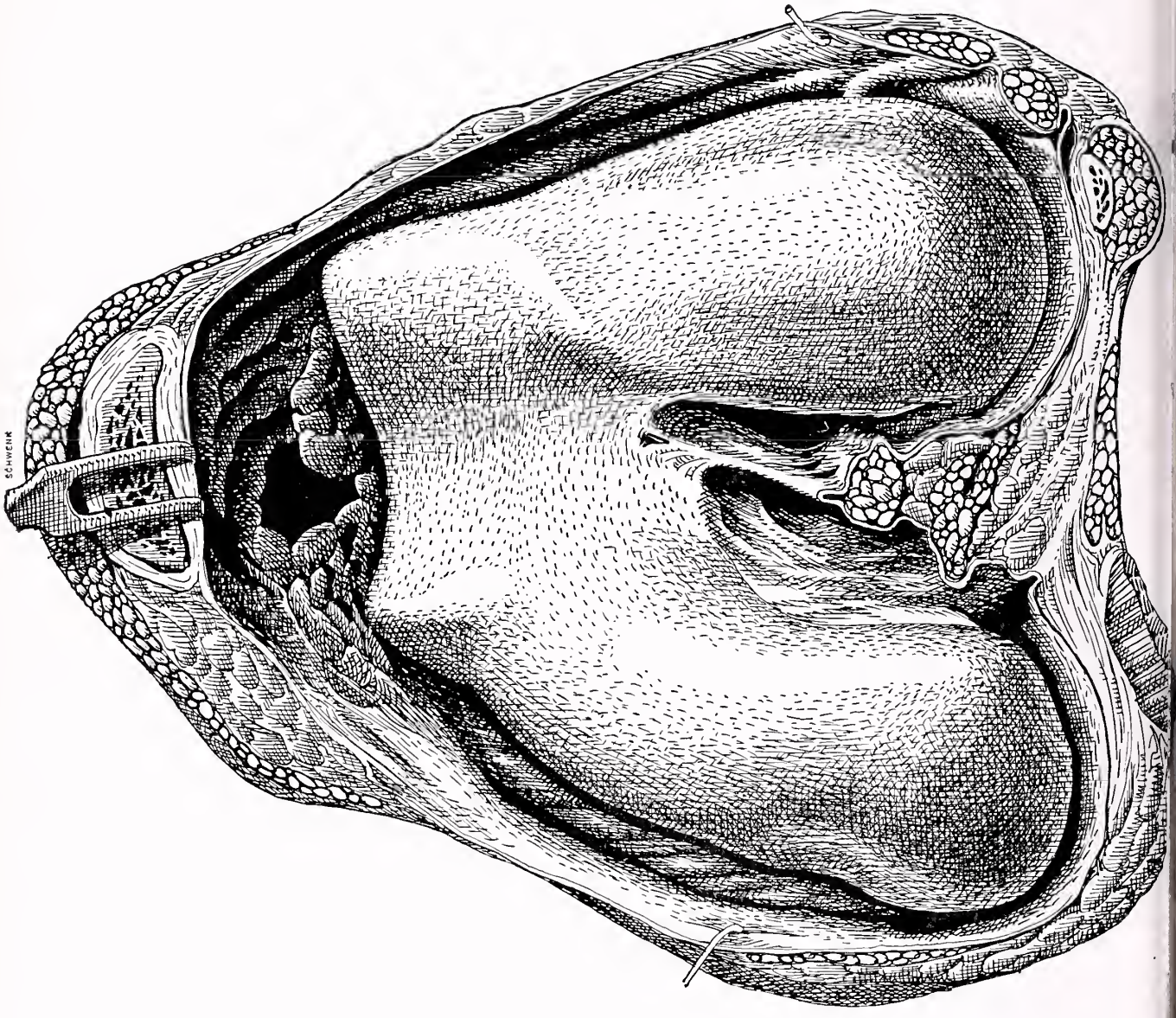
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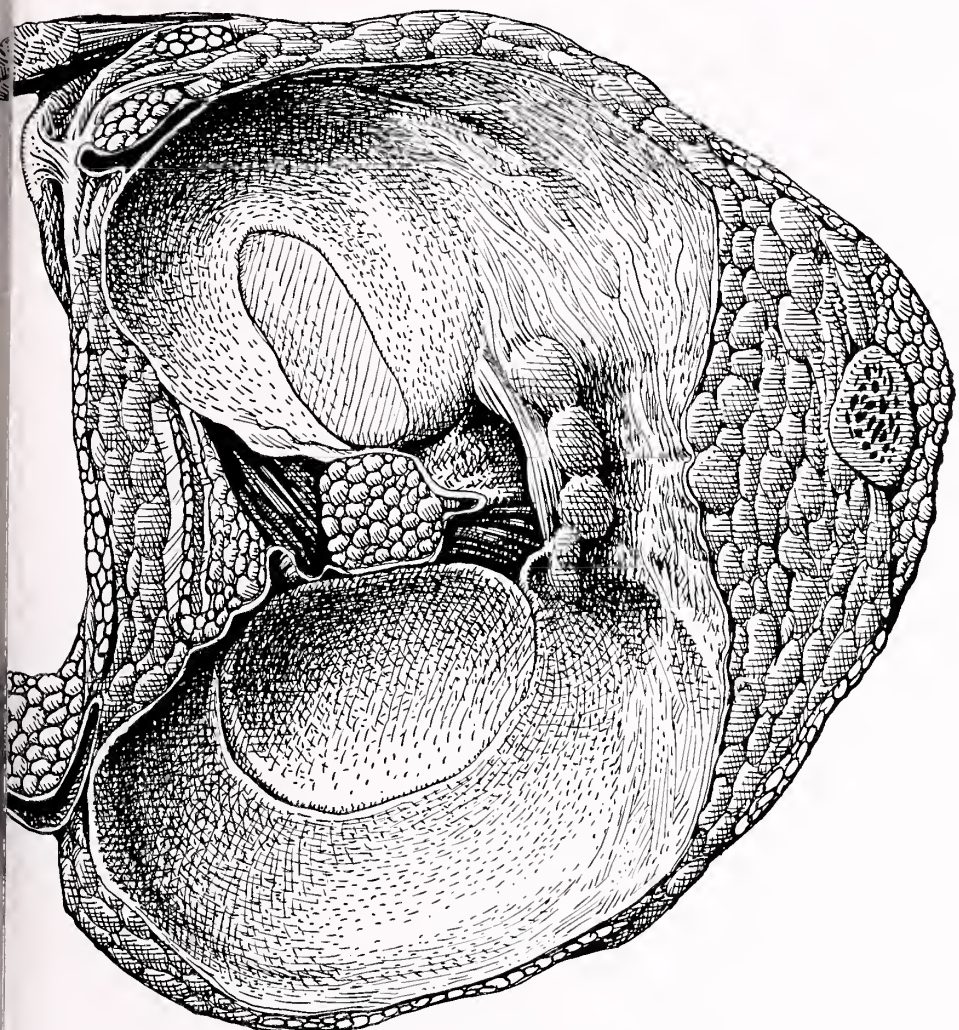
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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

BERYL UYEHARA, *Editor* — MAX BOWMAN, *Associate Editor*

Observations on Staphylococcus aureus Phage-Type 80/81 Hawaii and Its Resistance to Antibiotics

R. H. TANIMOTO, M.S.*

Ever since the staphylococcal bacteriophage typing service was instituted in Hawaii in 1956 and subsequently the Bureau of Laboratories of the Department of Health was designated as the regional staphylococcal phage typing center for Hawaii and the Pacific Trust Territory, cultures submitted with requests for bacteriophage typing increased enormously.

Staphylococcus aureus phage-type 80/81, appropriately labeled the "epidemic" strain and perhaps inopportunely the "hospital" strain, has remained for many years and still remains today the predominant phage-type encountered among the cultures submitted to the Health Department laboratory. In a talk delivered to the members of the Hawaii Society of Medical Technologists in 1959, and again in a paper published in 1960,[1] the author remarked, "Hawaii, although gifted in many respects, is no exception when it comes to possessing its share of antibiotic resistant Staphylococcus aureus phage-type 80/81." It was also emphasized at that time that 80/81 was no longer a sole possession of the hospitals but now a community property, thus forecasting an establishment of endemicity and vicious cycle of infections perpetrated by this strain of organism.

Thus, during the year 1958, a total of 2,012 Staphylococcus aureus cultures from hospitals, physicians and clinics were phage-typed. Of these, 30.3 per cent were found to be 80/81. Corresponding figures for 1959 were 21.1 per cent of 1,920 strains; for 1960, 24.8 per cent of 2,549 strains; and for the first six months of 1961, 22.8 per cent of 1,482 cultures, as shown in Table 1. On the

TABLE 1.—*Phage-type 80/81 Encountered Among Staph. aureus Cultures Submitted for Phage Typing (1958-60 and six months of 1961)*

YEAR	NUMBER OF STAPH. AUREUS CULTURES SUBMITTED	TYPE 80/81 FOUND	
		NUMBER	PER CENT
1958	2,012	610	30.3
1959	1,920	405	21.1
1960	2,549	631	24.8
1961 (Jan.-June)	1,482	338	22.8

TABLE 2.—*Two and One-half Year Distribution of Type 80/81 Strains Encountered Among Staph. aureus Cultures Submitted for Phage Typing (Jan. 1959–June 1961)*

YEAR AND QUARTER		SOURCE											
		HOSPITALS			PHYSICIANS & CLINICS			OTHER ISLANDS			TOTAL		
		NO. STAPH. AUREUS	NO. 80/81	%	NO. STAPH. AUREUS	NO. 80/81	%	NO. STAPH. AUREUS	NO. 80/81	%	NO. STAPH. AUREUS	NO. 80/81	%
1959	I	324	89	27.5	64	23	35.9	82	13	15.9	470	125	26.6
	II	292	72	24.7	63	12	19.0	74	7	9.5	429	91	21.2
	III	326	62	19.0	81	18	22.2	75	2	2.7	482	82	17.0
	IV	401	88	21.9	66	17	25.8	72	2	2.8	539	107	19.9
1960	I	493	140	28.4	56	24	42.9	50	6	12.0	599	170	28.4
	II	503	135	26.8	46	20	43.5	36	9	25.0	585	164	28.0
	III	561	111	19.8	70	19	27.1	46	9	19.6	677	139	20.5
	IV	598	131	21.9	65	22	33.8	25	5	20.0	688	158	23.0
1961	I	584	134	22.9	54	14	25.9	59	10	16.9	697	158	22.7
	II	668	150	22.5	77	23	29.9	40	7	17.5	785	180	22.9
2½ Yr. Total		4,750*	1,112	23.4	642	192	29.9	559	70	12.5	5,951	1,374	23.1

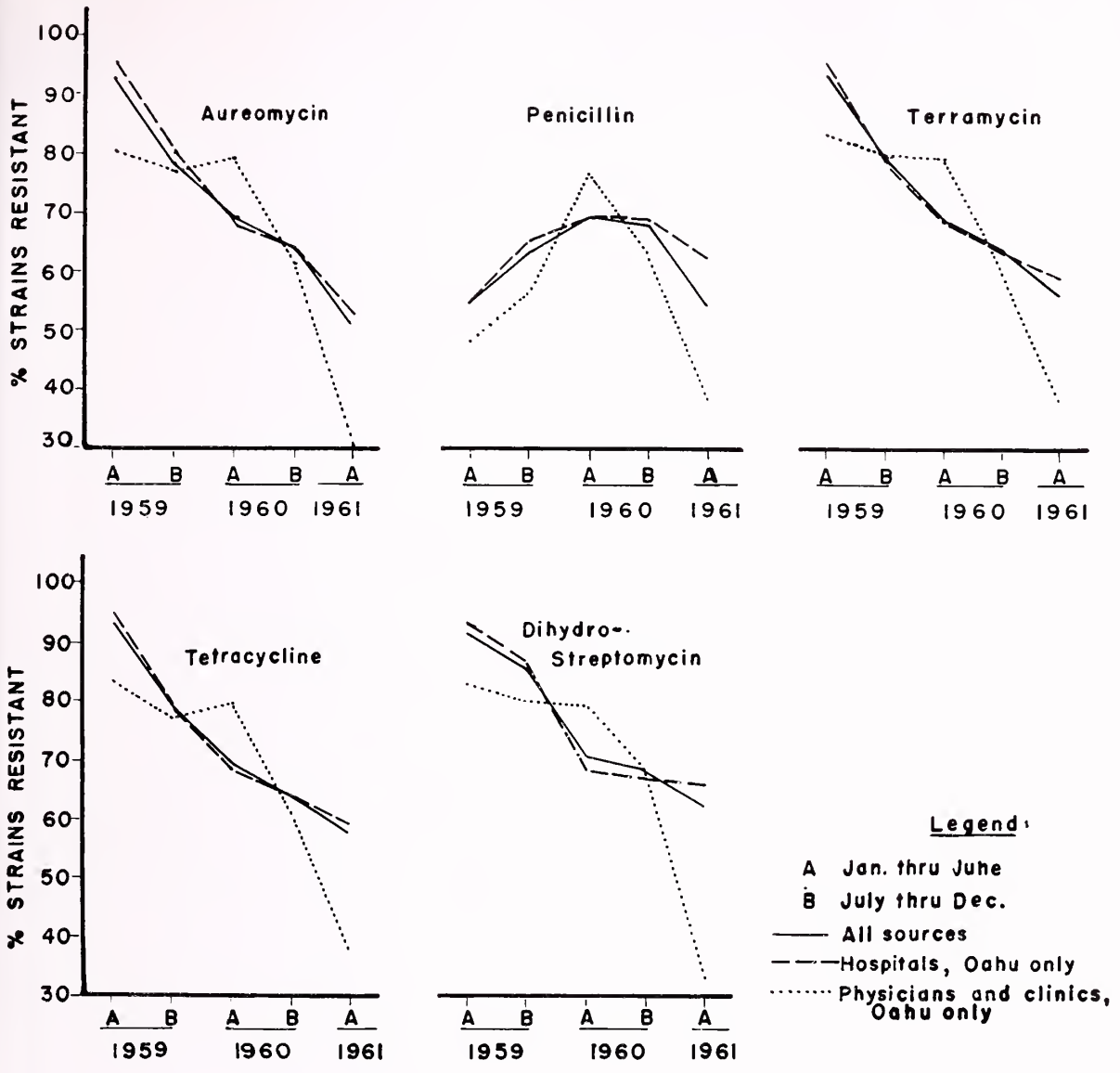
I, Jan. Mar.; II, Apr.-June; III, July-Sept.; IV, Oct.-Dec.

* 4,056 or 85.4 per cent of the cultures were submitted by four major hospitals in Honolulu. Distribution of type 80/81 strains were: Hospital A—21.8% of 412 cultures, Hospital B—20.4% of 1,224 cultures, Hospital C—21.8% of 1,375 cultures, and Hospital D—21.7% of 1,045 cultures.

* Assistant Chief, Bureau of Laboratories. Department of Health, Hawaii.

[1] Tanimoto, R. H. The Role of the Laboratory in the Detection and Control of Staphylococcal Epidemic in a Hospital. Hawaii Med. Jour. 19:607 (July-Aug.), 1960.

FIG. 2.—*Percentage Frequency of Antibiotic Resistant Strains Among Type 80/81 Staph. aureus Cultures (Jan. 1959–June 1961)*



average one out of every four to five cultures was of this "epidemic" type.

It is shown in Table 2 that during the past two and one-half years type 80/81 remained at an astonishingly high rate of occurrence among the cultures submitted to the laboratories of the Department of Health for phage typing, with no indication of a possible diminution. How reliable are these figures in the portrayal of an actual distribution of 80/81 in the hospitals and in the community?

In a cooperative study with one of the larger hospitals in May and June, 1959, nose and throat swabs from 300 individuals (staff and employees) were examined with a recovery of 80/81 from 14 or 4.7 per cent of the individuals. Similar study conducted in another hospital in September, 1959, revealed 80/81 in 5.4 per cent of 129 employees. The second study made in the same hospital in March and April, 1960, which comprised only the individuals having direct contact with obstetric and nursery units, showed 80/81 in 5.6 per cent of 54 individuals. In the eight-month study, 1959-60, of the incidence of nasal Staphylococcus aureus among mothers and babies in the same hospital, 80/81 was present in 11 or 2.7 per cent of 415 babies examined at the time of discharge from the hospital and in 9 or 2.2 per cent of 412 mothers, 7 of whom had 80/81 at the time of admission (unpublished data).

A staphylococcus infection survey of 1,017 individuals in an institution in May and June of 1960 showed 80/81 in the upper respiratory tract of 11.1 per cent of 72 employees and 5.8 per cent of 945 residents. Furthermore, type 80/81 was isolated from infected lesions of 24 individuals.

Of particular concern in the present evaluation of staphylococcus 80/81 in Hawaii is the significantly higher proportion of 80/81 encountered among the cultures submitted by physicians and clinics than among those submitted by hospitals per se, as illustrated in Fig. 1. In 1959, 23.2 per

TABLE 3.—*Antibiotic Resistance of Phage-type 80/81 Staph. aureus*

YEAR	1958	1959	1960	1961 (Jan.-June)	3½ YEARS AVERAGE
TOTAL CULTURES TESTED	610	405	631	338	1984
ANTIBIOTICS	PER CENT OF CULTURES FOUND RESISTANT				
Aureomycin, 5 mcg	82.2	86.3	66.7	50.3	72.9
Penicillin 2 units	75.8	58.4	68.8	54.7	66.5
Chloromycetin, 5 mcg	2.0	4.2	0.2	0.0	1.6
Terramycin, 2 mcg	46.5	86.7	66.9	56.5	75.3
Erythromycin, 5 mcg	6.0	15.8	8.1	0.6	7.8
Tetracycline, 2 mcg	86.4	86.5	66.7	57.1	75.2
Dihydrostreptomycin, 2 mcg	91.1	88.7	69.3	61.8	78.7
Oleandomycin, 2 mcg	.....	14.5	5.1	2.7	6.6
Bacitracin, 2 units	1.5	0.0	0.0	0.0	0.2
Neomycin, 5 mcg	1.1	0.9	0.0	0.0	0.4
Carbomycin, 2 mcg	.....	6.3	1.0	0.3	2.1
Novobiocin, 5 mcg	3.3	0.0	0.0	0.0	2.0

....., not done.

cent of 1,343 Staphylococcus aureus cultures submitted by hospitals were type 80/81 as compared with 25.5 per cent of 274 cultures submitted by physicians and clinics. Corresponding figures for 1961 were 24.0 per cent as compared with 35.9 per cent and for the first six months of 1961, 22.7 per cent as compared with 28.2 per cent.

The observations made on the resistance of Staphylococcus aureus cultures to various antibiotics as determined by the agar-disc diffusion method (Difco and Baltimore Biological Laboratory products) are presented in Table 3. It was found that 66.5 to 78.7 per cent of the 1,984 type 80/81 strains tested during the past 3½ years were found to be resistant to aureomycin, penicillin, terramycin, tetracycline, and dihydrostreptomycin as compared with only 7.8 per cent resistant to erythromycin, 6.6 per cent to oleandomycin, 2.1 per cent to carbomycin, 2.0 per cent to novobiocin, 1.6 per cent to chloromycetin, 0.4 per cent to neomycin, and 0.2 per cent to bacitracin. It is worthy of note that not one of the 1,374 80/81 strains tested during the past 2½ years was found to be resistant to bacitracin and novobiocin and not a single culture of the 969 strains tested during the past 1½ years was resistant to neomycin. During the first six months of 1961 a total of 338 strains were tested of which two were found to be resistant to erythromycin, one to carbomycin, and none to chloromycetin, bacitracin, neomycin, and novobiocin.

The figures presented in Table 4 indicate a steady decrease in the percentage of antibiotic resistant 80/81 strains encountered during the past 2½ years.

During the first quarter of 1959, 94.4 per cent of 80/81 strains were found to be resistant to aureomycin as compared with only 55.0 per cent for the second quarter of 1961. Corresponding decreases observed with other antibiotics were penicillin 72.8 to 61.7 per cent, terramycin 95.2 to 57.8 per cent, tetracycline 95.2 to 58.9 per cent, dihydrostreptomycin 91.2 to 62.8 per cent, erythromycin 12.8 to 0.6 per cent, and oleandomycin 10.4

TABLE 4.—*Resistance of Phage-type 80/81 Staph. aureus to Antibiotics (by Quarters)*

YEAR & QUARTER	NO. STRAINS TESTED	PER CENT OF CULTURES FOUND RESISTANT TO:											
		AUR.	PEN.	CHL.	TER.	ERY.	TET.	STR.	OLE.	BAC.	NEO.	CAR.	NOV.
(1959)													
I	125	94.4	72.8	6.4	95.2	12.8	95.2	91.2	10.4	0	0	3.2	0
II	91	91.2	28.6	5.5	92.3	26.4	91.2	93.4	19.8	0	1.1	12.1	0
III	82	75.6	52.4	2.4	75.6	12.2	75.6	86.6	13.4	0	1.2	2.4	0
IV	107	81.3	72.0	1.9	81.3	13.1	81.3	84.1	6.5	0	0.9	3.7	0
(1960)													
I	170	67.1	66.5	0.6	67.1	10.6	67.1	67.6	5.3	0	0	0.6	0
II	164	70.7	72.6	0	71.3	14.6	71.3	73.2	6.1	0	0	0.6	0
III	139	74.1	73.4	0	74.1	4.3	73.4	74.1	5.8	0	0	1.4	0
IV	158	55.7	63.3	0	55.7	1.9	55.7	62.7	3.2	0	0	1.3	0
(1961)													
I	158	44.9	46.8	0	55.1	0.6	55.1	60.8	3.8	0	0	0.6	0
II	180	55.0	61.7	0	57.8	0.6	58.9	62.8	1.7	0	0	0	0

I, Jan.-Mar.; II, Apr.-June; III, July-Sept.; IV, Oct.-Dec. AUReomycin 5 mcg., PENicillin 2 units, CHLoromycetin 5 mcg., TERramycin 5 mcg., ERYthromycin 2 mcg., TETracycline 5 mcg., DihydroSTREptomycin 2 mcg., OLEandomycin 2 mcg., BACitracin 2 units, NEOmycin 5 mcg., CARbomycin 2 mcg., NOVobiocin 5 mcg.

TABLE 5.—*Resistance to Antibiotics of Phage-type 80/81 Strains Submitted by Hospitals and by Clinics and Physicians (Jan. 1959–June 1961)*

ANTIBIOTICS	HOSPITALS					PHYSICIANS AND CLINICS				
	1959		1960		1961	1959		1960		1961
	A	B	A	B	A	A	B	A	B	A
	NUMBER OF CULTURES TESTED									
	161	150	275	242	284	35	35	44	41	37
	PER CENT OF CULTURES FOUND RESISTANT									
Aureomycin, 5 mcg.	95.0	79.3	67.6	64.0	52.5	80.0	77.1	79.5	61.0	30.0
Penicillin, 2 units	54.7	65.3	69.1	69.0	62.7	48.6	57.1	77.3	63.4	37.8
Chloromycetin, 5 mcg.	5.5	2.7	0.3	0	0	0	0	0	0	0
Terramycin, 5 mcg.	95.7	78.7	68.0	64.0	59.2	82.9	80.0	79.5	61.0	37.8
Erythromycin, 2 mcg.	15.5	14.0	14.5	3.3	0.4	5.7	8.6	2.3	0	0
Tetracycline, 5 mcg.	95.0	79.3	68.0	63.6	59.5	82.9	77.1	79.5	61.0	37.8
Dihydrostrep., 2 mcg.	93.2	86.7	68.4	67.4	65.5	82.9	80.0	79.5	68.3	32.4
Oleandomycin, 2 mcg.	16.1	7.3	6.9	5.0	2.8	5.7	17.1	0	0	2.7
Bacitracin, 2 units	0	0	0	0	0	0	0	0	0	0
Neomycin, 5 mcg.	0.6	1.3	0	0	0	0	0	0	0	0
Carbomycin, 2 mcg.	8.1	4.0	0.7	1.7	0.7	0	0	0	0	0
Novobiocin, 5 mcg.	0	0	0	0	0	0	0	0	0	0

A=Jan. thru June B=July thru Dec.

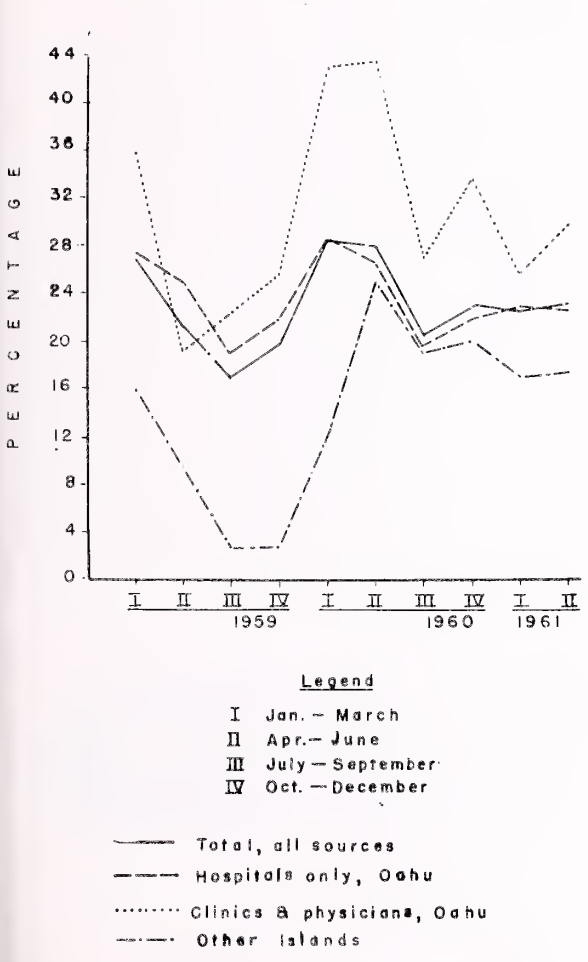


FIG. 1.—*Frequency Distribution of Type 80/81 Strains Encountered Among Staph. aureus Cultures Submitted by Source (Jan. 1959–June 1961)*

to 1.7 per cent. The decreasing trends were apparent with all antibiotics tested and not limited to one or two specific antibiotics.

Undoubtedly a certain number of the cultures submitted by the hospitals were obtained from their outpatient clinics or from newly admitted patients who probably had the infection prior to admission. Conversely, some of the cultures submitted by physicians and clinics were obtained from patients recently discharged from hospitals or who had acquired the infection from such individuals.

Table 5 shows that there were, proportionately, more antibiotic resistant 80/81 strains among the cultures submitted by the hospitals than among those submitted by physicians and clinics. As illustrated in Fig. 2, the declivitous trend of 80/81 among the specimens received from physicians and clinics commenced after the middle of 1960 and the difference in the percentage distribution of resistant strains between the two sources became significantly noticeable since the beginning of 1961. Thus, for the first six-month period of 1961, the percentage of resistant strains among "hospital" cultures as compared with "physician" cultures were 52.5 against 30.0 per cent in the case of aureomycin, 62.7 against 37.8 per cent with penicillin, 59.2 against 37.8 per cent with terramycin, 59.5 against 37.8 per cent with tetracycline, and 65.5 against 32.4 percent in the case of dihydrostreptomycin.

Acknowledgment

The author gratefully acknowledges the technical assistance provided by Mr. Lewis Nutting, Mr. John Terredanio and Mrs. Mary Tanouye of the Bureau of Laboratories, Department of Health.

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COUNTY SOCIETY REPORTS

(Continued from page 246)

The minutes of the previous meeting were read by Dr. Tomita. It was moved, seconded and passed that the minutes be approved.

The following doctors were welcomed into the Society by President Hartwell: Drs. Anna M. Brault, Walter Y. M. Chang, Richard T. Mamiya and Michael M. Okihiro.

Approval of Chapter IV, Section 3 of the Bylaws pertaining to HMSA was deferred to the next meeting. It was felt that more time was needed to study this section to be sure that the contents of this change was in line with the Society's new contract with HMSA.

It was moved by Dr. Felix that this section of the Bylaws be voted on at the next meeting. The motion was seconded and carried.

The chair announced that HMSA has agreed to drop their request to raise the income ceiling from $9,000 to $12,000 and that Dr. Frazer and Dr. Ewing were very instrumental in HMSA's decision not to raise the income ceiling at this time. Dr. Berk related briefly the details of his committee's meeting with HMSA on this subject and stated that his committee has a report ready for the Board of Governors and also a complete answer for HMSA's problems. Dr. Ewing who was asked to report on the meeting of HMSA at which this matter was discussed, stated that the important thing was that the Executive Committee unanimously voted to leave everything the way it was.

Howard Pearce gave a progress report of the present status of the Honolulu Foundation and also presented some information regarding the Stockton Foundation Plan and Blue Shield's participation in the plan.

The meeting adjourned at 9:40 P.M.

RICHARD D. MOORE, M.D.
Secretary

Maui

A meeting of the Maui County Medical Society was called to order by the President, Dr. S. Ohata, at 9:00 P.M. on Thursday, September 14, 1961, following a staff meeting of the Central Maui Memorial Hospital.

Guests present: Doctors Haling and Wallis.

The President appointed the following doctors to serve on the Physicians Procurement Committee: Dr. Iaconetti, Chairman; Doctors Andrews; Ohata; and Underwood.

The President stated that he had a long telephone conversation with Chief Lane of the Police Department regarding the County's responsibility to perform autopsies on unattended deaths. These autopsies were previously performed by government physicians. Chief Lane has requested suggestions from the County Society as to who should perform these autopsies. A motion was made and seconded that, with Dr. Moran's approval, he be appointed autopsy surgeon for all County autopsies on a fee-for-service basis. Motion was unanimously passed.

A letter from Dr. Francis Wong, Secretary of the Hawaii County Medical Society, was read stating that Dr. Kenneth Haling was a member in good standing of

(Continued on page 268)



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COUNTY SOCIETY REPORTS

(Continued from page 266)

that Society. It was moved, seconded and unanimously passed that Dr. Haling be accepted as a member of the Maui County Medical Society.

Copies of a letter from the ILWU regarding emergency care by non-participating physicians for ILWU members were made and circulated to all of the doctors.

A letter from Dr. Lichter requesting the Society for examining patients in the hospital was read.

WILLIAM E. IACONETTI, M.D.
Acting Secretary

* * *

The regular meeting of the Maui County Medical Society was held on October 24, 1961, at the Vineyard Chop Suey. Dr. Iaconetti called the meeting to order at 8:10 P.M. Guests present: Doctors Graumann, Hendershot, Anderson, Wallis, Dusenberry, Mr. Yuen, and Mrs. Louise Smith.

Dr. Marion Hanlon presented the highlights of a October, 1961, pediatric meeting held in Chicago.

Mr. Yuen, representing HMSA, discussed the master agreement of the Medical Society and HMSA. Dr. Burden moved, and Dr. Kashiwa, seconded, that the Medical Society sign this agreement with HMSA. The motion was unanimously carried. Dr. Fleming moved, and Dr. Hanlon seconded, that the changes in the surgical fee schedule (4.5 relative fee schedule) be approved. This was unanimously carried. The Medical Society was asked by Mr. Yuen to submit the names of three doctors, one of whom will be elected as a director of HMSA.

A letter from Dr. Burden was read which concerned the AMA and hearings on the King-Anderson Bill. Dr. Sanders moved, and Dr. Shimokawa seconded, that the Maui County Medical Society go on record as supporting the AMA in their stand on this Bill.

C. F. MORAN, M.D.
Secretary

AMA DELEGATE'S REPORT

(Continued from page 247)

Agreed with the Trustees that $250,000 was too much to spend on an AMA exhibit at the 1964-65 New York World's Fair.

Rejected a resolution requiring that drugs be given only nonproprietary names.

Recommended that state and county societies stop developing their own simplified insurance claim forms.

Took a sharp look at allocation of Federal money for research grants largely to big university centers.

Received cautiously for study a resolution urging that tax funds be used to make voluntary health insurance cheaper for the elderly.

Approved the Trustees' view that the FDA should keep out of the job of determining the efficacy of new drugs.

Supported income tax deductions for medical expenses for the elderly (HR7756, the Hall Bill).

Reaffirmed in the strongest terms their opposition to welfare type health legislation (see editorial, this issue).

Approved both three- and two-year residencies in anesthesiology, recognizing that the latter is the "usual pattern."

Instructed the Council on Medical Education and Hospitals to study the proposed American Board of Abdominal Surgery.

Commended Mrs. Harlan English and the Woman's Auxiliary, of which she is President, for their accomplishments and their constructive program.

Rejected a plea that the AMA's nearly-implemented lifetime disability insurance program might break local plans.

HARRY L. ARNOLD, JR., M.D.
A.M.A. Delegate

COUNCIL MEETING MINUTES

(Continued from page 247)

hiro, [Maui], Kenneth Haling (transfer from Hawaii). Deletions—July [Hawaii], Kenneth Haling (transfer to Maui); August [Hawaii], Y. Miyashiro (transfer to Honolulu), [Honolulu], C. Kusunoki (deceased), [Maui], William Totherow (transfer to California); September [Honolulu], A. McGinnis (transfer to Ohio), I. MacQuarrie (honorary, deceased), [Maui], Edward Kushi (deceased). Classification changes—Au-

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gust [Honolulu], Frances Nakamura (active to associate), W. Meister (associate to active); September [Honolulu], George Straub (honorary to life), I. Katsuki (honorary to life), [Kauai], Robert Worth (honorary to associate). Adjustments—December [Hawaii], G. Asami was inadvertently omitted from active membership report; April [Hawaii], new active member, H. Bockrath, was not previously reported.

The total membership in July was 625; August, 626; September, 629. There have been no formal requests for waiver of dues.

ACTION:

It was moved, seconded, and passed that we accept the Secretary's report.

Dr. West called attention to that section of the bylaws referring to waiver of dues. They state that dues of members over 70 will automatically be waived regardless of county action and list five criteria for the waiver of a member's dues which have been wholly or partially waived by his county society. A lengthy discussion followed of the practicability of accepting the county's actions in each case and the different policies followed by the different counties.

ACTION:

It was moved and seconded that the HMA go along with the waiver and reduction of dues in accordance with the action taken by a member's county society. The motion failed to pass after a tie vote was broken by the President's casting a negative ballot.

It was moved, seconded, and passed by a vote of six to two that the waiver of dues be confined to the criteria set forth in the bylaws.

REPORT OF THE TREASURER

The circulated financial reports were discussed briefly. Dr. Arnold was asked to comment on the decline of JOURNAL revenues and explained that this was due to the curtailment of pharmaceutical advertising.

The financing of Mabel Smyth Building improvements was discussed at length.

ACTION:

It was moved, seconded, and passed that the Treasurer be permitted to use funds for Mabel Smyth Building improvements provided proper safeguards are incorporated in the transaction.

The out-of-pocket costs of those attending the AMA's meetings were reviewed as were the per diem expenses of the councilors.

ACTION:

It was moved, seconded, and passed that the neighbor island councilors' per diem allowance be increased from $10.00 to $20.00.

The cost of holding Council meetings on the neighbor islands was compared to the benefits that accrue. Dr. West questioned the advisability of requiring at least one meeting a year to be held on a neighbor island. Dr. Burden thought this policy was impracticable and pointed out that there seemed to be some misunderstanding about the purpose of such meetings.

ACTION:

It was moved, seconded, and passed that the present mandatory policy of holding at least one Council meeting a year on a neighbor island be changed and that these meetings be scheduled on neighbor islands only when the Council so desires that they be held there.

Dr. Richert spoke on the system of subsidizing the Woman's Auxiliary. He suggested that instead of the Auxiliary's giving money to the Physicians' Benevolent Fund, the excess money they had left over in their budget should be given back to each individual county at the rate of $1.00 per member per year. Dr. Benson felt that the HMA should stay out of this. Dr. Burden thought it was within the State's jurisdiction to allot this money, however, he would write the Woman's Auxiliary and thank them for the gift of $400.00.

The Oahu Health Council's request for increased support was discussed. Dr Burden asked if he could allot an additional $50.00 from his contingency fund to this organization this year and suggested that consideration of their request be given when next year's budget is made out. It was agreed that the $50.00 allotment was within the President's province.

ACTION:

It was moved, seconded, and passed that the Treasurer's Report be accepted.

REPORTS OF STANDING AND SPECIAL COMMITTEES

Federal Medical Services Committee: Dr. Burden asked that this report be considered under new business.

Legislative Committee: Dr. Liljestrand advised that he was present at the Council meeting to answer questions regarding the letter he had written relative to engaging a lobbyist. He also hoped he would get some advice on the recommendations set forth by the House of Delegates at its last meeting which were that the membership be kept better informed on legislative matters and that the Association engage a lobbyist. He spoke on the low batting average the HMA experienced during the last session and outlined the qualifications he

(Continued on page 272)

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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COUNCIL MEETING MINUTES

(Continued from page 269)

thought a lobbyist should possess. If a lobbyist is engaged, the member doctors would still have to appear at hearings on request. The cost of engaging a lobbyist would perhaps be two to five thousand dollars a session. He thought that if the doctors want to do anything to influence health legislation, they would have to start thinking about spending money. The pros and cons of this proposal were discussed at length. Dr. Liljestrand asked whether the committee should concern itself with all legislation as taxpayers or should it confine its activities to medical matters. Dr. Burden thought that the members of the Association should be kept informed on how to present their views to the members of the Legislature. Dr. Yamauchi spoke on his experience over the past several years and brought out the importance of getting our views to the legislators before the session begins, even years in advance. Dr. Burden asked Dr. Liljestrand to explore the situation more fully and bring back a definite proposal outlining exactly how much it would cost and a recommendation on whom he would recommend for the assignment.

ACTION:

It was moved, seconded, and passed to approve the suggested lobbyist program in principle pending a definite recommendation from the chairman of the Legislative Committee.

Chronic Illness and Aging Committee: Dr. Yamauchi advised the Council of the four forthcoming Senate subcommittee hearings on the aged to be conducted in Hawaii by Senator Long. If the HMA accepts the invitation to appear at these hearings, the Secretary should send a letter to the Commission on Aging. Present plans call for the various chairmen of the Aging Committee's sub-sections to prepare reports which Mr. Lytle will compile and coordinate in making up a presentation which it is hoped Dr. Burden will present at the hearing. Dr. Burden hoped that other physicians more eloquent than he would make the presentation in Honolulu. He thought that someone should appear at each of the hearings and questioned if it would be wise for him to appear at all of them. Dr. Yamauchi gave a resumé of his committee's activities and the workings of the Governor's Interim Commission on Aging. Dr. Burden felt that the entire committee should be present at the hearings in Honolulu and that each county society should appoint the person who is best informed on this subject to appear at the hearing on his island, and that the material get into the hands of the people who agree to participate as soon as possible.

Two important mainland meetings on aging are scheduled this fall, to which we have been invited. The cost of sending someone to attend these meetings was discussed and it was decided that it would be better to spend money on the local hearings rather than to send someone to the mainland.

Hawaii Medical Journal: Dr. Arnold reported that the nurses have decided to withdraw from the JOURNAL and the last time they will participate will be the January-February, 1962, issue. We have been advised that the loss in circulation will not affect the advertising rates and since the nurses have been getting the JOURNAL for less than it costs to print it, a saving should be effected. This change will necessitate a new cover.

(Continued on page 274)

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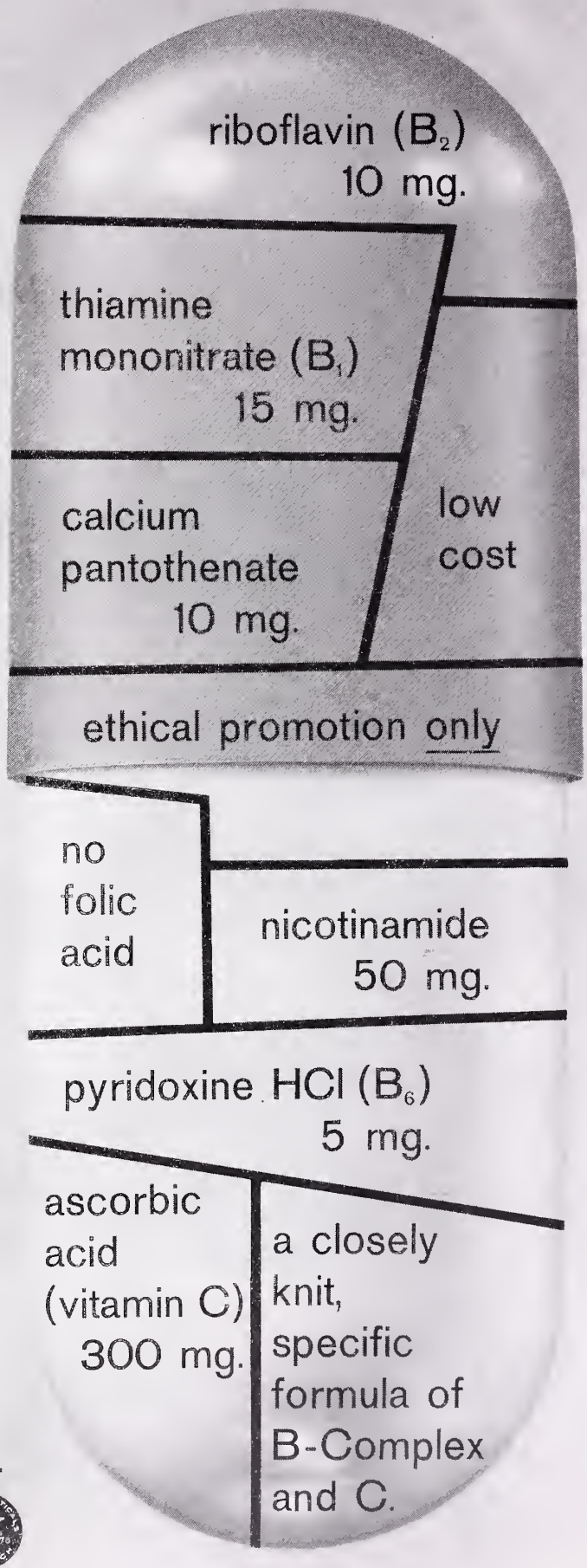
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COUNCIL MEETING MINUTES

(Continued from page 272)

He submitted three proposed designs. He also advised that the Advertiser Publishing Company submitted a quotation for printing the JOURNAL which is approximately $200.00 an issue less than we are now paying. It was noted that we have no assurance that this difference would be maintained and we have not had an increase in printing costs since 1957. A discussion followed on whether the difference justifies breaking in a new publishing firm. It was thought that the Star-Bulletin is doing a good job.

ACTION:

It was moved, seconded, and passed that the decision on changing printers be left to the JOURNAL staff.

Hospital Liaison Committee: The Committee's report and the state-wide survey proposed by the Hawaii Hospital Association were discussed.

ACTION:

It was moved, seconded, and passed that the proposed hospital survey be approved.

Editor's Report

Dr. Arnold reported on the recent Journal Conference and advised that the HAWAII MEDICAL JOURNAL received a rating of 84. The journal which received the highest rating, 93, was Oklahoma. Of the 34 journals which participate in SMJAB, only 11 rated higher than Hawaii.

UNFINISHED BUSINESS

It was noted that the three neighbor island counties had asked for a $5.00 fee for filling out Social Security disability application forms. Honolulu invited the director of the local Social Security office to attend one of its meetings and at that time announced they would not ask for this fee. Mr. Pearce advised that the action was taken because it was the patient who asked for the benefits and so the costs should be borne by him, not the Social Security office.

The revised Bylaws, which include mandatory AMA membership, were discussed. It was noted that this change had received wide dissemination. One Honolulu member had made a telephone complaint. Kauai County Medical Society voted to approve the change. It was suggested that notice of the change be made in the Newsletter the first of the year.

NEW BUSINESS

Dr. Burden said that the need for a Negotiating Committee is apparent, as is the need for its being on a state level. He was gratified when Honolulu invited representatives from the neighbor islands to discuss final proposals for revision of the HMSA contract. He thought the committee that works with the new State employees' health insurance benefits plans should be on a state level. The relationship of the HCMS Medical Care Plans Committee and the HMSA was discussed. Dr. Burden thought this committee should be made a state committee with one representative from each neighbor island appointed to it. The matter of a uniform fee schedule throughout the State of Hawaii was discussed. It was felt that there is no longer any differential existing among the counties. It was noted that the HCMS Medical Care Plans Committee is elected and could not be converted to a HMA committee according to the present HCMS bylaws. Dr.

(Continued on page 276)

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COUNCIL MEETING MINUTES

(Continued from page 274)

West told how the HMA fee schedule committee was abrogated in 1948 when a relative value schedule was first proposed. Mr. Pearce said it was thought that a negotiating committee should be a continuing committee. Dr. Burden suggested adding members to the Federal Medical Services Committee and making it the negotiating committee. Mr. Pearce outlined the present status of the State's plans for initiating health insurance benefits. Kaiser, one commercial underwriter, and HMSA will make plans available to State employees. HMSA will probably carry this group under one of their regular plans. The bids must be in by November 13.

ACTION:

It was moved, seconded, and passed that the HMA and HCMS presidents confer on the matter of medical care plans which encompass the entire State to try to work out some agreeable solution which will satisfy all counties.

Dr. Burden advised that he had received letters from the Veterans Administration relative to canceling the present agreement. He had looked over the fee schedule submitted and it appeared to be somewhat inadequate.

ACTION:

It was moved, seconded, and passed that the matter of negotiating a new contract with the Veterans Administration be referred to the Federal Medical Services Committee and that the VA be asked for an extension of time.

The meeting adjourned at 11:50 P.M.

RODNEY T. WEST, M.D.
Secretary

BOOK REVIEWS

(Continued from page 245)

could well be placed high on the must reading for residents and beginners. Old timers will add a lot to their knowledge of vascular surgery.

I looked for more credits to Blakemore for his influence in teaching the importance of a knowledge of vascular repair. Certainly, it was he who in 1940 aroused my enthusiasm. I looked in vain for some mention of the syndrome of spasm and thrombosis of the popliteal artery, following minor athletic injuries.

The bibliographies are excellent. I recommend the book for either casual reading or as a reference work to turn to for help in surgical techniques.

D. B. BELL, M.D.

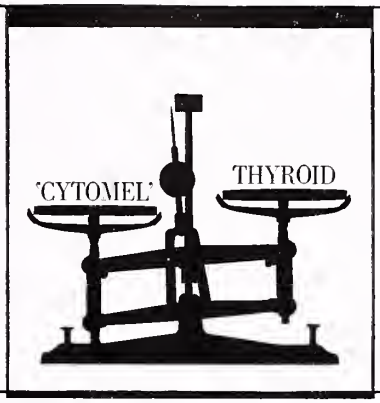
Relief of Symptoms, 2d Ed.

By Walter Modell, M.D., F.A.C.P., 374 pp., $11.50, The C. V. Mosby Co., 1961.

The fact that this book is appearing in its second edition is evidence that there was a need for a text that would deal with symptom relief in contrast to treatment of causes. After developing a rather strong argument that the very modern medical man has adopted an almost contemptuous attitude toward symptom relief as he pursues his more important goal of irradication of the causative factors, Dr. Modell notes that the physician who ignores the relief of the patient's symptoms may cause him to seek the help of the charlatan who directs all efforts to symptom relief without any concern for cause. Written in a rather informal style with frequent expression of personal opinions, the book is

(Continued on page 278)





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Most patients should be started on 25 mcg. of 'Cytomel' daily. To increase dosage to recommended maintenance levels for these patients, increments of 12.5 or 25 mcg. may be made in the daily dosage at intervals of one or two weeks. Dosages in the range of 100 mcg. daily, and higher, are well tolerated by many patients.

When starting dosage is 5 mcg. daily (as in myxedema, male infertility, simple goiter and in patients being switched from thyroid, L-thyroxine, or thyroglobulin), increments of 5 or 10 mcg. may be made in the daily dosage at intervals of one or two weeks. When dosage reaches 25 mcg. daily, increase as described above.

'Cytomel' is usually administered in divided doses.

Note: In geriatric patients or in children always start with 5 mcg. daily and adjust dosage in increments no greater than 5 mcg.

Indication	Recommended Starting Dose	Recommended Maintenance Dose
Hypometabolism Mild Hypothyroidism	25 mcg. daily	25-75 mcg. daily (Smaller doses may be fully effective in some patients.)
Myxedema	5 mcg. daily	50-100 mcg. daily
Female Reproductive Disorders	25 mcg. daily	25-50 mcg. daily
Male Infertility (Based on sperm count or sperm motility responses after two to four weeks of treatment at a given dosage level, the daily dosage may be increased hy 5 or 10 mcg. If after further treatment the desired response has still not been obtained, the daily dosage may again be increased. Although total daily dosage usually need not exceed 25 mcg., as much as 50 mcg. daily may be used if necessary.)	5 mcg. daily	10-25 mcg. daily
Simple (non-toxic) Goiter	5 mcg. daily	25-75 mcg. daily

SPECIAL CONSIDERATIONS AND CAUTIONS: Tachycardia, excitability, headache, or excessive sweating are signs of overdosage. Medication should be interrupted until the unpleasant symptoms disappear, and then resumed in smaller doses. Since the return to pretreatment status is rapid, 'Cytomel' can usually be resumed at the desired dosage after one to two days.

When a subnormal BMR exists as part of the clinical syndrome of hypometabolism or hypothyroidism, administration in excessive dosage will cause elevation of BMR to levels above normal.

'Cytomel', unlike various forms and fractions of thyroid, will not cause elevation of the blood protein iodine level.

Endogenous thyroid gland function, reflected particularly by I^{131} uptake, may he depressed by 'Cytomel' administration. Depression of this function is most apt to occur with higher dosages (greater than 75 mcg. daily). Experience to date indicates that this effect is not clinically harmful. There have been no unfavorable sequelae in reported instances where 'Cytomel' therapy has been discontinued after depression of I^{131} uptake occurred. In such cases this function has promptly returned to normal after discontinuance of 'Cytomel'.

Since 'Cytomel' is physiologically related to thyroxine, it is not recommended for use in the presence of angina pectoris, in other cardiovascular disorders, or ischemic states. However, if it is used in the presence of such conditions, the starting dosage should never be more than 5 mcg. daily. If dosage is increased, it should be in increments of no more than 5 mcg. daily at approximately two-week intervals.

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Prescribing information adopted Jan. 1961

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BOOK REVIEWS

(Continued from page 276)

quite readable. It does not replace, nor was it meant to replace, *Manuals of Therapy,* and although there is some overlap with textbooks of therapeutics, there is very little real duplication of effort. The greatest value of this book is probably to the medical student or young practitioner who has not yet acquainted himself with the art of symptom relief. The more experienced practitioner who has repeatedly encountered such problems as insomnia, gas, constipation, and so forth will also find much useful information in this book.

FRED I. GILBERT, JR., M.D.

★Clinical Endocrinology

Edited by Edwin B. Astwood, M.D., 724 pp., $18.75, Grune & Stratton, 1960.

I have enjoyed this excellent workbook on clinical and basic endocrinology so much that I have been reluctant to return it to the Hawaii Medical Library for approximately one year—much to the distress of the librarian.

In this book, sharp lines have not been drawn between what is clinical and what might be considered nonclinical. The emphasis is mainly on clinical matters and reports on investigative research which seek to reach a fuller understanding of normal and abnormal endocrine processes in human beings. It is apparent that this work was undertaken and directed towards the needs of practitioners. This book is certain to prove popular with all physicians who are seriously interested in clinical endocrinology.

Complete coverage of the field has not, of course, been attempted in this single volume. The classical and well-established material may be found in standard texts on clinical endocrinology and, therefore, has been omitted to make way for topics selected largely on the basis of their current interest and importance. I found the section on "Hormone Assays and Special Tests" of particular interest. The chapter on "Tests of Adrenocortical Reserve, Pituitary Reserve, and Pituitary-Adrenal Suppressibility" by Grant W. Liddle, M.D., is exceptionally well presented.

The list of contributors is composed of outstanding teachers and investigators in endocrinology; for example, Louis J. Soffer, Randall G. Sprague, Gregory Pincus, B. E. C. Nordin, Rachmiel Levine, Joseph W. Jailer, and Alexander Albert. There are 82 contributors to this volume.

It is with great reluctance that I return this book after one year to its proper owner, the Hawaii Medical Library. I hope that other physicians will enjoy this book as much as I have.

RALPH M. BEDDOW, M.D.

Clinical Disturbances of Renal Function

By Abraham G. White, M.D., F.A.C.P., 468 pp., $10.50, W. B. Saunders, 1961.

This text by a man who has had vast research and clinical experience in renal physiology and renal diseases is by far the most complete text I have seen of this type. The references are voluminous, but the method of approach in its writing makes it quite easily digested. It would be an easy reference for the internist as well as the urologist who is called upon frequently to diagnose and treat primary renal dysfunction. The chapters on renal dysfunction and electrolyte imbalance are of particular interest and the diagrammatic descriptions certainly make for a much better understanding of this problem.

ANDREW L. MORGAN, M.D.

Nursing Home Adminstration

By John D. Gerletti, Ed.D., C. C. Crawford, Ph.D., and Donovan J. Perkins, M.S., 472 pp., $6.50, Attending Staff Association, 1961.

The book results from a research project, participated in by members of the California Nursing Home Association. The project was financed by Federal funds, administered through the California State Department of Public Health, for the purpose of improving patient care in nursing homes and similar facilities.

Based on a compilation of problem areas assessed by nursing home administrators, the text is focused principally on needs peculiar to this type facility. It is a non-technical, practical encyclopedia, written in simple terms for the untrained administrator. It could be used advantageously as a guide for formal training or in self-instruction.

Emphasis is placed on the factors affecting comprehensive care and services within the nursing home. Relationships beyond the home with family, medical and paramedical professions, official agencies, and other groups are discussed.

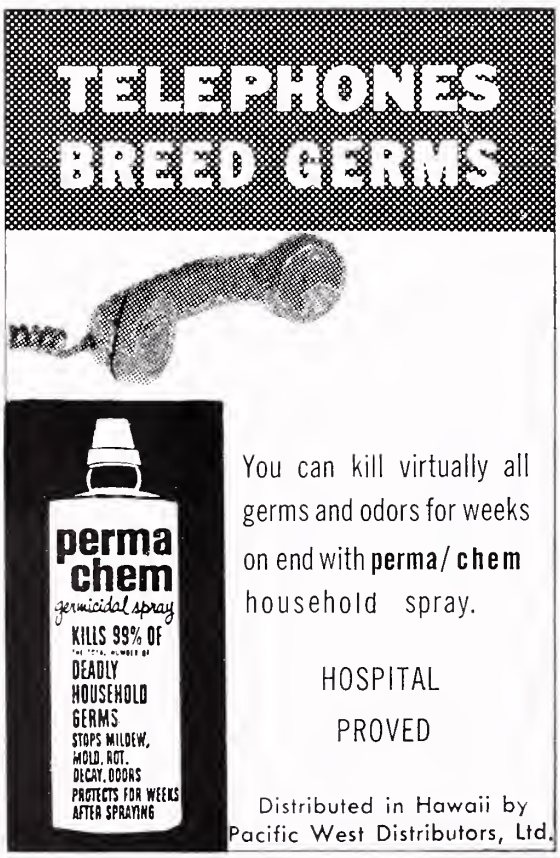
MARGARET G. BENNETT, R.N.

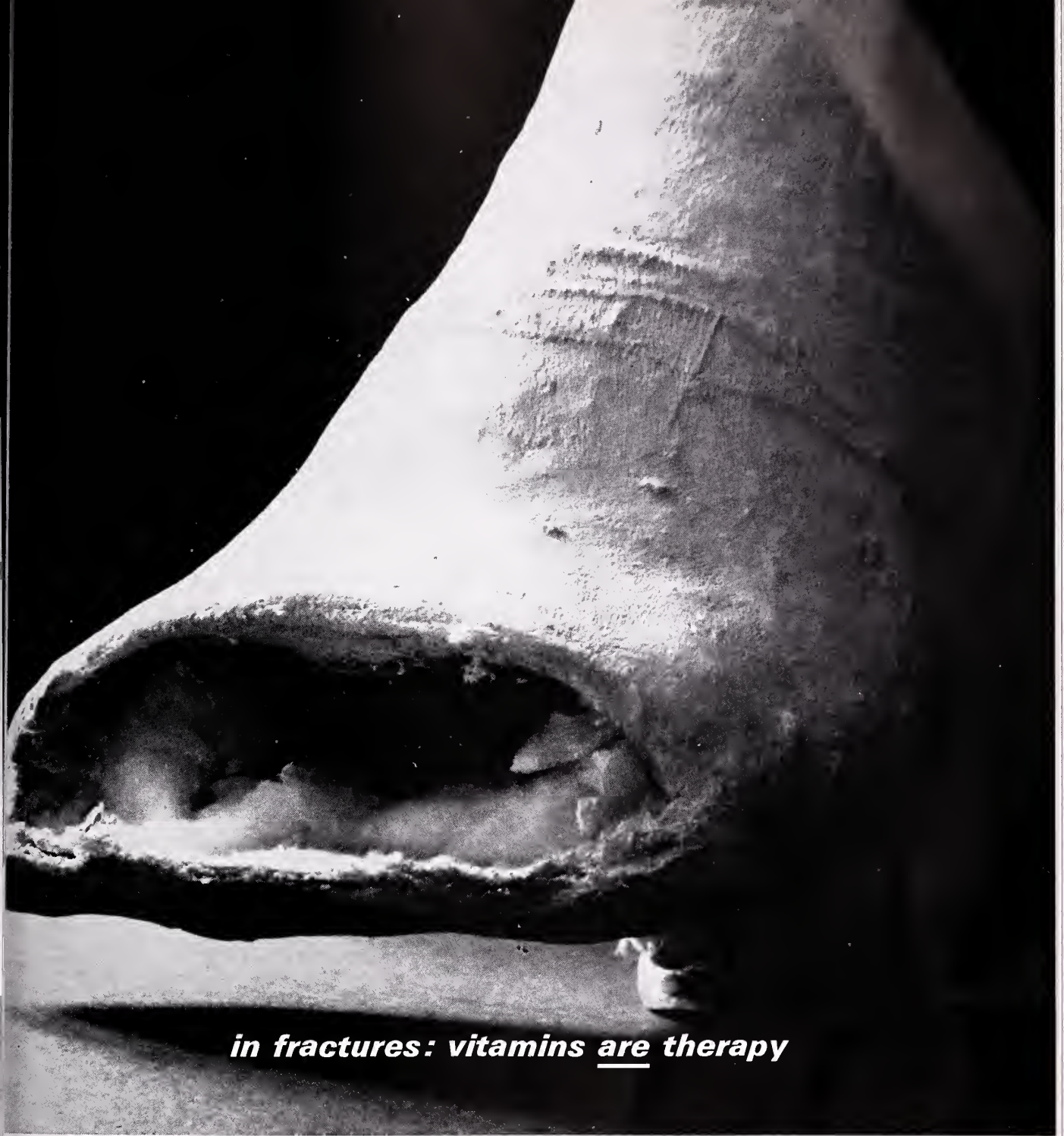
Mayo Clinic Diet Manual, 3rd Ed.

By The Committee on Dietetics of the Mayo Clinic, 222 pp., $5.50, W. B. Saunders Company, 1961.

This is a complete diet manual for use of the dietician, physician, and nurses, but not to be handed to the pa-

(Continued on page 282)





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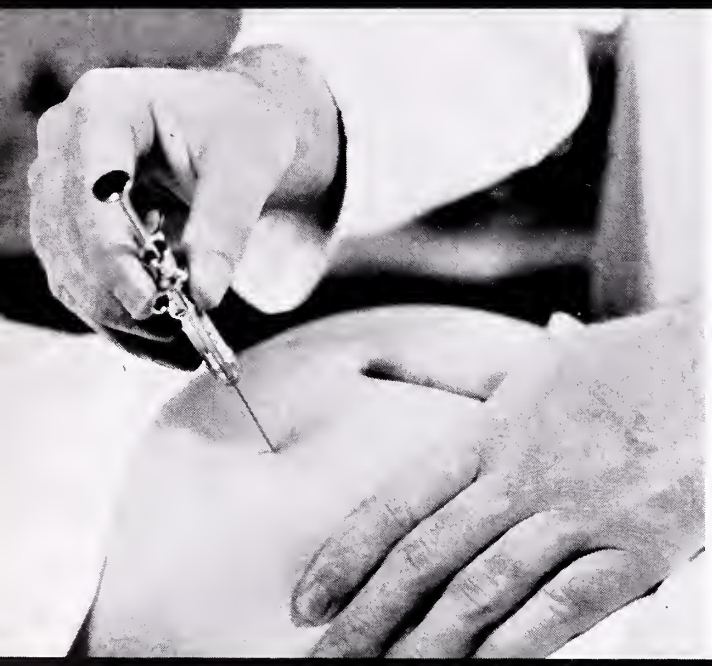
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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. **2.** J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. **3.** J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. **4.** W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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BOOK REVIEWS

(Continued from page 278)

tient, for it is too technical. Few physicians would want a copy in their office, but almost all dieticians should have this book. One must use the facilities at his disposal, and the reviewer finds the *Hawaii Diet Manual,* which is followed by The Queen's Hospital, adequate for his general needs.

The diabetic diets in the Mayo book are not the now popular exchange diet promulgated by the American Diabetic Association, but are the more difficult computed calorie diets.

I found the appendix an easy source for finding foods categorized as high in iron, high in potassium, low in sodium, etc. There is also other highly useful information. But I wonder whether it might not be worthwhile for every diet manual to offer as a package deal a set of scales with gram weights.

C. S. Brown, M.D.

★Anatomy: Regional and Applied, 2d Ed.

By R. J. Last, M.D., B.S. (Adel.), F.R.C.S., 741 pp., $15.00, Little, Brown & Co., 1959.

The contents of this book are exactly what the title offers. It has good illustrations of the various regions with adequate descriptions. The important regions with their associated structures are depicted in color as a means of differentiating the various structures.

This book will be a fine addition to a busy practitioner's library.

Wallace W. S. Loui, M.D.

Heredity in Ophthalmology

By Jules Francois, 731 pp., $23.00, The C. V. Mosby Co., 1961.

The title of this book is rather deceiving, for the author discusses all eye conditions. He classifies them from a hereditary point of view, i.e., whether the disease is dominant or recessive. When studied from this stand, the origin of eye diseases takes on a more meaningful approach. Even if one disregards the place of heredity in ophthalmology, because of its nontherapeutic applications, the author's descriptions of the various diseases and the photographs make this a worthwhile book for an ophthalmologist's personal library.

Wayne Wong, M.D.

Abdominal Operations, 4th Ed.

By Rodney Maingot, F.R.C.S., 1402 pp., $29.50, Appleton-Century-Crofts, Inc., 1961.

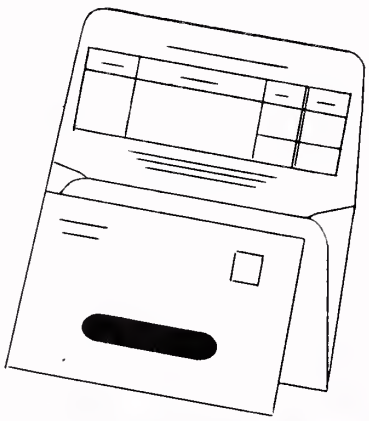
This to me represents a welcome addition to the library of any resident or practitioner interested in the abdominal phase of surgery. Its coverage is most complete; the presentation is clear. The illustrations are numerous and exceedingly well done. The author and his contributors —of whom there are many—are representative of the best in their respective fields, and each section is clearly, completely, yet concisely presented.

Although all interested in abdominal surgery would benefit from this book's perusal, it is a book full of surgical subtleties and is of increasing value as one's surgical experience broadens.

R. Rose, M.D.

(Continued on page 284)

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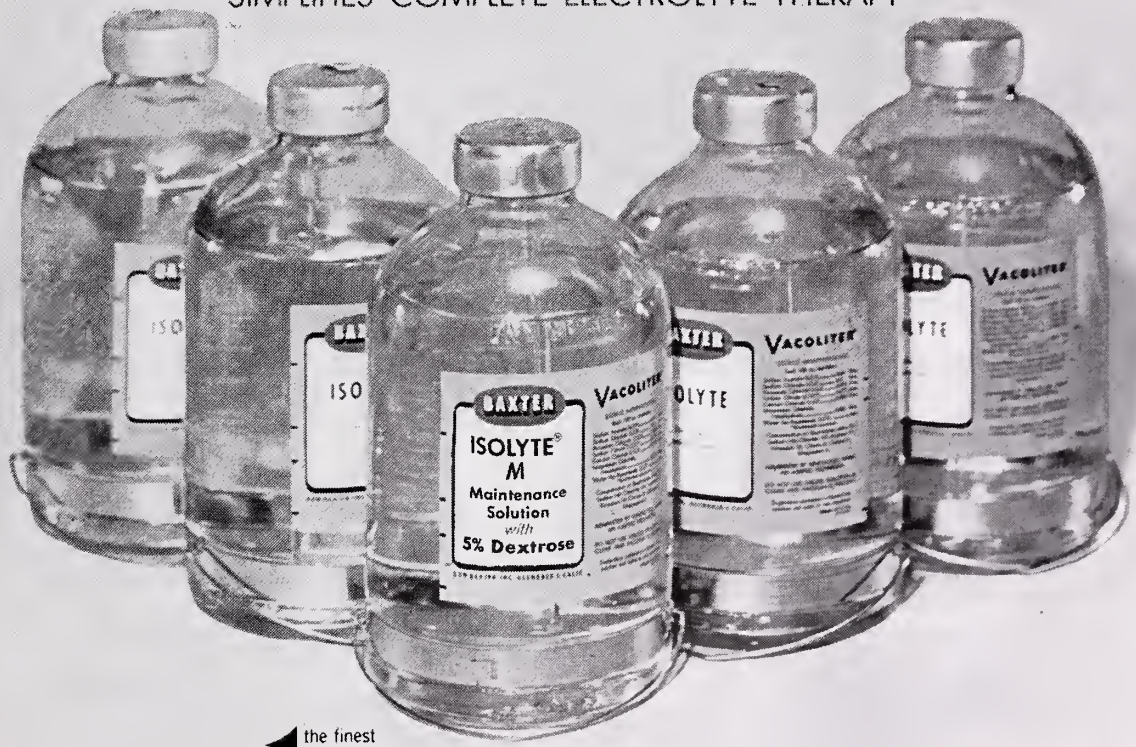
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BOOK REVIEWS

(Continued from page 282)

Pathologic Physiology, 3rd Ed.

By William A. Sodeman, M.D., Sc.D., F.A.C.P., 1182 pp., $15.00, W. B. Saunders Co., 1961.

With the great emphasis on deranged physiology in medicine today, this volume is an admirable attempt at describing such changes in the field of internal medicine between two covers. Despite the shortcomings of multiple authorship and sketchiness of coverage in some areas, the authors manage to do a handsome job. The bibliography is adequate and covers recent work.

BERNARD J. B. YIM, M.D.

Clinical Diagnosis by Laboratory Examinations, 3rd Ed.

By John A. Kolmer, M.S., M.D., Dr.P.H., Sc.D., LL.D., F.A.C.D. (Hon.), 543 pp., $10.00, Appleton-Century-Crofts, Inc., 1961.

The third edition of this one of Kolmer's texts removes the complaint of bulkiness which may have been applied to the previous two editions. One should understand that this is not the Kolmer and Boerner work. The book is very compact, the pages glossy, the print legible, and the binding durable.

The motto facing the preface, although not new, is too often ignored. "No clinical laboratory examination can be better than the thoroughness and skill with which it is conducted."

If one remembers this, then the book is an excellent summary of the results of laboratory examinations in their influence of the diagnosis of the patient's condition. The work incorporates the latest acceptable laboratory procedures to a great extent and is probably as up to date as any in the field. Nevertheless, this book does not emphasize that its results are only the ideal and that patient variation is as important as laboratory technique. However, no book in the field does this.

Despite the above criticism, I found this a compact and useful guide to the interpretation of laboratory results.

W. HAROLD CIVIN, M.D.

★Cardiovascular Dynamics

By Robert F. Rushmer, M.D., 503 pp., $12.50, W. B. Saunders Co., 1961.

This volume is more appropriately titled than the previous edition—Cardiac Diagnosis: A Physiologic Approach. The author has succeeded in molding together clinical, pathological, and physiological thought in a broad field. Despite its size, the volume covered the topic quite completely and adequately. References are plentiful although not completely updated. *Cardiac Dynamics* is a volume that should be in all medical libraries.

BERNARD J. B. YIM, M.D.

★Recognizing the Depressed Patient

By Frank J. Ayd, Jr., M.D., 138 pp., $3.75, Grune & Stratton, 1961.

This is a very good book which can be read with profit by the specialist as well as the nonspecialist. There is a wealth of clinical material which summarizes the

(Continued on page 286)

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BOOK REVIEWS

(Continued from page 284)

clinical experience and deep insight of the author. It is a psychiatric book which emphasizes psychiatry as a medical specialty that fits into the general medical field. The description of the physical complaints of the psychoneurotic, depressed patient is especially good. This book presents a worthwhile discussion of problems every medical man meets in everyday practice.

J. ROBERT JACOBSON, M.D.
BY JOHN J. PHILLIPS

Rehabilitation of a Child's Eyes, 3rd Ed.

Revised by Herbert Katzin, M.D., F.A.C.A., and Geraldine Wilson, R.N., 107 pp., $3.75, C. V. Mosby Co., 1961.

The book is designed primarily for the parents of a child who has a tropia. It is meant to supplement and clarify for the parents what they misunderstood or misinterpreted in the ophthalmologist's office. It carefully covers the whys and wherefores of procedures which may be used in attempting to cure the child.

My office always has had several copies available on loan to parents. I am still not sure how much good it does. Simple as the diagrams are, the language still seems above the heads of many, and the ophthalmologist must get his points across personally.

The diagrams in the new edition are mostly the same but of much better quality and definition, although a few still are somewhat ambiguous to the average person. I do not know if the smaller print helps or not—at least it no longer has the appearance of a child's primer. The chapter on amblyopia has been shortened considerably to the detriment of the book.

I do recommend this book be available in every ophthalmologist's office for the edification of parents with children having crossed eyes.

THOMAS P. FRISSELL, M.D.

★What Teenagers Want to Know

By Florence Levinsohn, B.A., M.A., in consultation with G. Lombard Kelly, A.B., B.S.M., M.D., 89 pp., $1.50, Budlong Press Co., 1961.

This booklet is a remarkably complete discussion of the problems confronting "teenagers." It is written in language and form geared to the teenager's comprehension.

It is recommended to anyone having to do with the adolescent: physicians, teachers, ministers, counselors, and social workers

D. C. MARSHALL, M.D.

Also Received

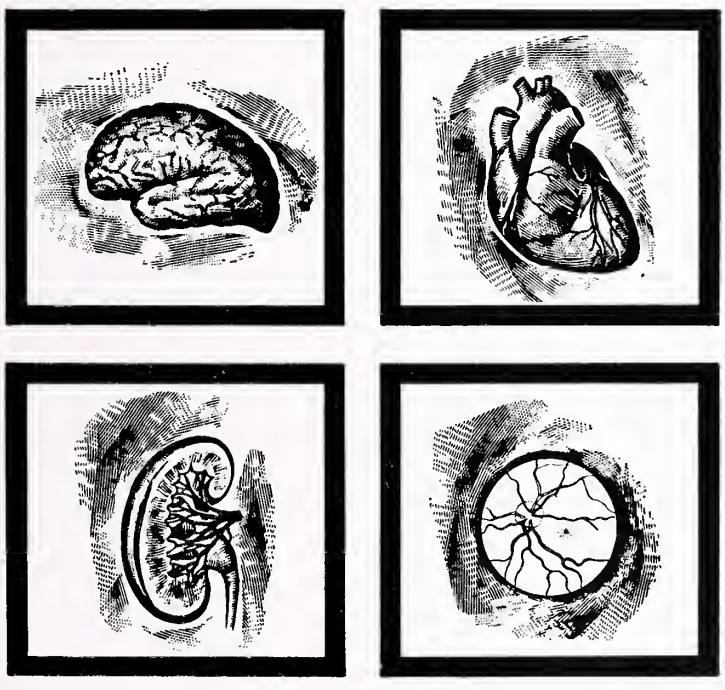
Preventive Medicine in World War II Vol. V, Communicable Diseases

Editor in Chief, Colonel John Boyd Coates, Jr., M.C., 530 pp., $5.75, U.S. Government Printing Office, 1960.

A detailed and authoritative documentary, of absorbing interest to students of epidemiology, communicable disease control, or military medicine.

(Continued on page 288)

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(Continued from page 286)

Science and Psychoanalysis, Vol 4

Jules H. Masserman, M.D., Editor, 196 pp., $6.75, Grune & Stratton, 1961.

Psychoanalysis and social process. An Academy of Psychoanalysis publication.

A Biochemical Basis of Multiple Sclerosis

By Roy L. Swank, M.D., Ph.D., 88 pp., $5.00, Charles C. Thomas, 1961.

A biochemical hypothesis of the cause of multiple sclerosis.

Medical Pharmacology

By Andres Goth, M.D., 551 pp., $11.00, C. V. Mosby Co., 1961.

More for medical students than for physicians, but good for both.

The Chemistry of Brain Metabolism in Health and Disease

By J. H. Quastel, Ph.D., D.Sc. and David M. J. Quastel, M.D., C.M., 170 pp., $6.50, Charles C. Thomas, 1961.

Internists and psychiatrists should read this.

Systematic Observation of Gross Human Behavior

By G. R. Pascal and W. O. Jenkins, 126 pp., $4.75, Grune & Stratton, Inc., 1961.

Psychologists and psychiatrists only.

Clinical Obstetrics and Gynecology, Vol. 4, No. 2

Edited by Robert E. L. Nesbitt, Jr., M.D., A. N. Arneson, M.D., and James F. Nolan, M.D., pp. 309-592, Paul B. Hoeber, Inc., June, 1961.

Two symposia, one on perinatal mortality and the other on radiation therapy of the female reproductive tract.

The Medical Clinics of North America, Vol. 45, No. 4

Howard F. Conn, M.D., Guest Editor, pp. 669-1114, 1961.

A review of the efficacy of some of the newer drugs.

Pediatric Clinics of North America, Vol. 8, No. 3

Carroll F. Burgoon, Jr., M.D., Consulting Editor, 673-965 pp., W. B. Saunders Company, August, 1961.

Symposium on pediatric dermatology with 17 contributors.

(Continued on page 292)



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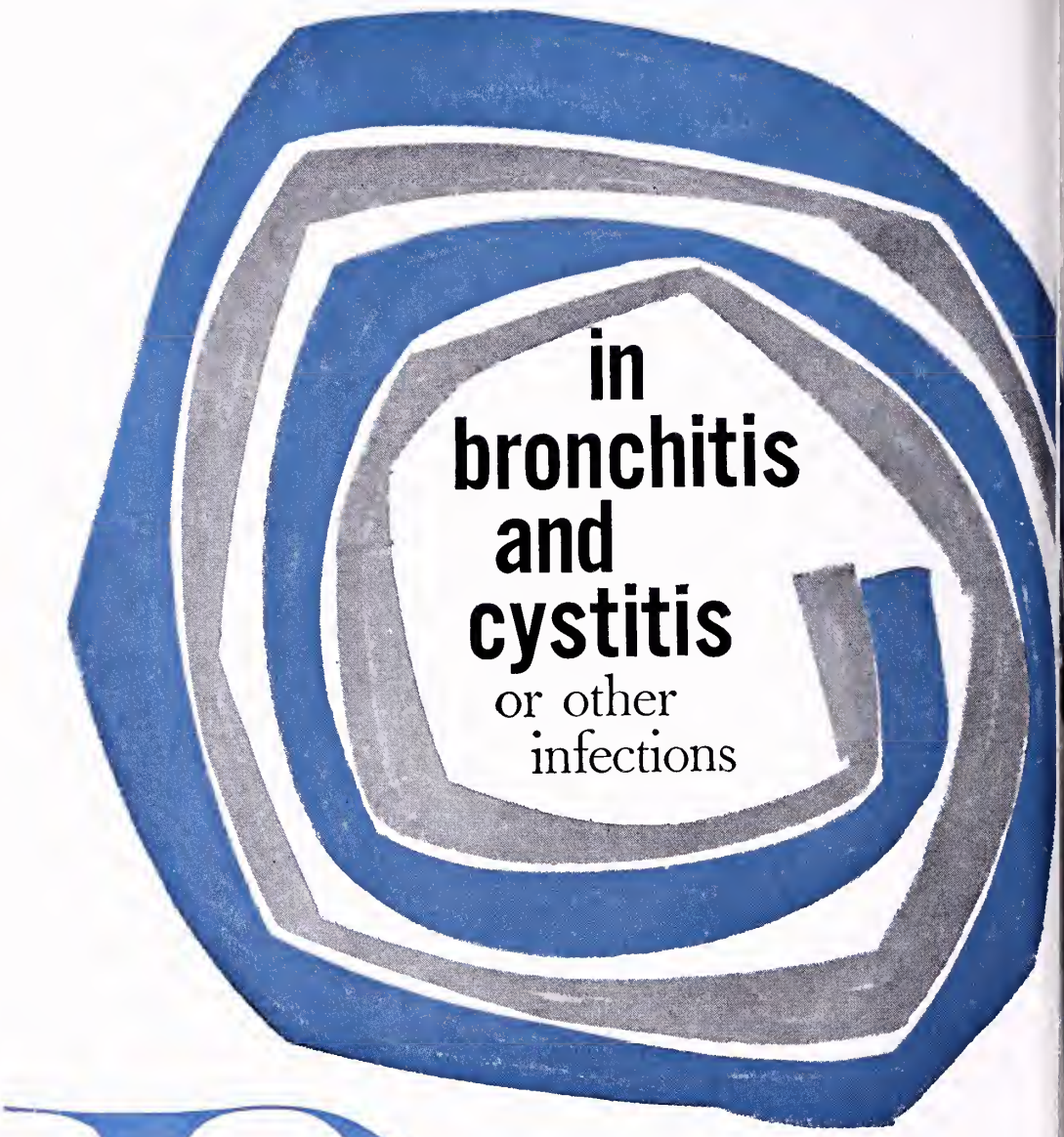
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The Surgical Clinics of North America, Vol. 41, No. 4

Mayo Clinic Number, 865-1140 pp., W. B. Saunders Company, August, 1961.

This volume deals with difficult diagnostic problems in surgery. Forty-six contributors.

The Surgical Clinics of North America, Vol. 41, No. 3

Pp. 545-863, W. B. Saunders Co., June, 1961.

A Lahey Clinic Number on thoracic surgery, exclusive of the heart.

The Medical Clinics of North America, Vol. 45, No. 3

By David A. Karnofsky, M.D., Rulon W. Rawson, M.D., pp. 501-778, W. B. Saunders Co., May, 1961.

The staff of the Memorial-Sloan-Kettering Cancer Center has dedicated this symposium on medical aspects of cancer to the memory of Dr. Cornelius P. Rhoads.

Pediatric Clinics of North America, Vol. 8, No. 2

By R. James McKay, Jr., M.D., Consulting Editor, pp. 409-671, W. B. Saunders Co., May, 1961.

A symposium dealing with new knowledge and controversial subjects relating to the care of the newborn.

Ciba Foundation Symposium on the Nature of Sleep

G. E. W. Wolstenholme and Maeve O'Connor, Editors, 416 pp., $10.00, Little, Brown and Company, 1960.

Fascinating discussions!

Annals of the New York Academy of Sciences, Vol. 92, Art. 1

Franklin N. Furness, Editor, 331 pp., The New York Academy of Sciences, 1961.

Vitamins.

British Medical Bulletin, Vol. 17, No. 2

By K. W. Cross, Editor, pp. 79-176, Medical Department, The British Council, May, 1961.

A symposium on fetal and neonatal physiology which includes papers on aspects of placental histology, fetal endocrinology, and the chemoreceptors and their function in the aortic-pulmonary body.

Annals of the New York Academy of Sciences, Vol. 92, Art. 3

Nathan S. Kline, Conference Editor, Franklin N. Furness, Editor, 813-1198 pp., The New York Academy of Sciences, July, 1961.

This series of papers is the result of the Pavlovian Conference on Higher Nervous Activity, cosponsored by The New York Academy of Sciences of the United States and The Academy of Medical Sciences of the Union of Soviet Socialist Republics, held in New York August, 1960. Twenty-five contributors.

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	Page
Abbott Laboratories	Insert (between pages 206 and 207) 280, 281
Ames Company, Inc.	210, 295
Ayerst Laboratories	296
Baxter, Don, Inc.	283
Blackfield Enterprises	292
Burroughs Wellcome	206, 218, 252, 253, 285
Carnation Company	207
Chrones Bldg.	284
Ciba Pharmaceuticals	287
Coca-Cola Bottling Co.	274
Endo Laboratories	289
Ethicon	208, 209
Foster Equipment	268
Hawaii Medical Service Association	242
Hawaiian Airlines	276
International Travel	266
Lederle Laboratories	215, 260, 261, 279, 290, 291
Lilly, Eli, & Co.	197, 220
Lorillard, P., Co.	213
McKesson & Robbins, Inc.	250
Mead Johnson International	204, 205
Medical Industries	266
Medical Placement Bureau	286
O'Leary, Lydia, of Hawaii	286
Optical Dispensers	274
Pacific West Distributors, Ltd.	278
Parke, Davis Company	198, 199
Pfizer Laboratories	Insert (between pages 266 and 267)
Pharmaceutical Manufacturers	293
Professional Services, Inc.	288
Robins, A. H., Co., Inc.	201, 219, 273
Saunders, W. B., Co.	211
Schering Corp.	217
Schuman Carriage Co., Ltd.	272
Searle, G. D., & Co.	251
Smith, Kline & French	277
Spencer, Frank, C., M.D.	269
Squibb, E. R., & Sons	216, 270, 271
Star-Bulletin Printing Co., Inc.	282
Summers, Clinton D.	Insert
Tailby-Nason Co.	275
Universal Motors	267
Von Hamm-Young Co., Ltd.	294
Warren-Teed Products	212
Williams Mortuary	259
Winthrop Laboratories	203

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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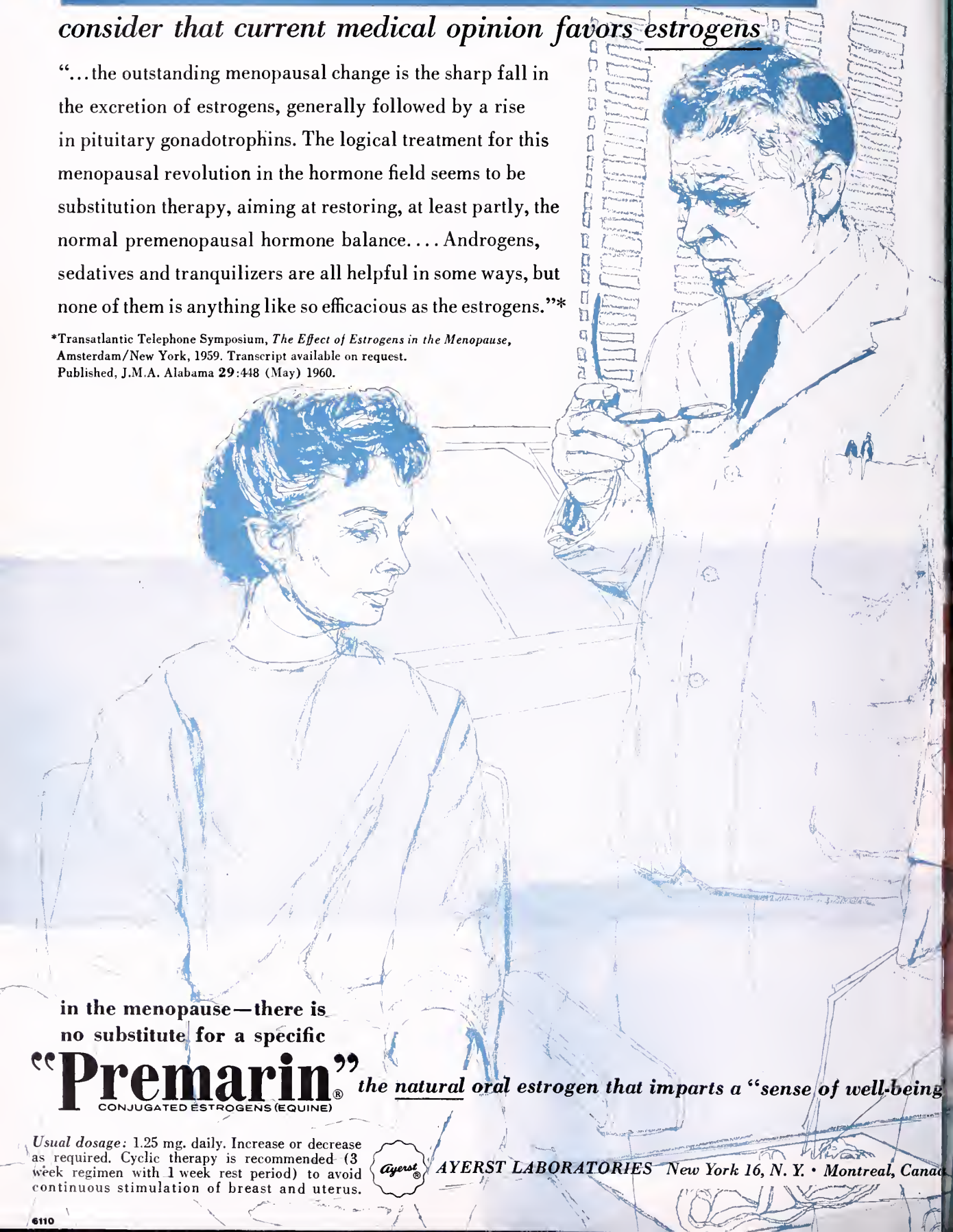
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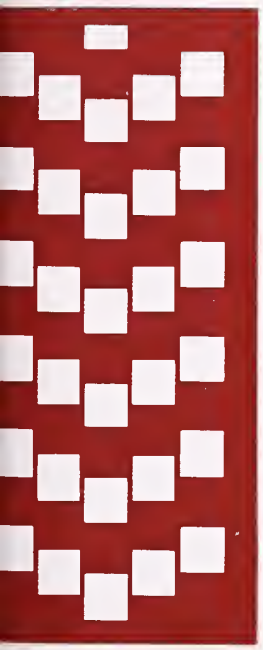
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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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Correspondence

Oral Polio Vaccine

TO THE EDITOR:

In reference to your recent editorial entitled "No Hurry For Oral Polio Vaccine" in which you cited Dr. David Bodian's opinions on the matter, may I offer the following comments in reply. First, it is important to realize that the prospective use of Sabin's live attenuated vaccine presents an entirely new concept in immunomedicine; there is no analogous vaccine in current or widespread use today. The details to be considered in its use, therefore, require consideration of many factors probably new to most practitioners. Interference, contact spread, local tissue immunity, and so on, not to mention the statistical studies offered pro or con for a particular type vaccine, all are some of these details.

Dr. Bodian's thesis as presented in *Science* presents many sound observations, and voices objections which should be seriously considered. However, I respectfully take issue with some of his conclusions. Confining myself to those points raised in the recent HAWAII MEDICAL JOURNAL editorial, I would like to offer these observations for your consideration. There is no question of the efficacy of Salk inactivated vaccine in reducing the morbidity and mortality from paralytic polio. Dr. Bodian, however, questions whether the Sabin vaccine could have done as well in this country. The ultimate answer can never be found. Conditions in this country at the start of the Salk vaccine immunizations will never be the same again; the whole polio picture has been subsequently changed by the use of this vaccine. Nevertheless, there is more than ample evidence from the studies done in Singapore, Russia, Mexico and elsewhere and in the United States that the attenuated vaccines are at least equally effective in those aspects of epidemiology which are comparable; they are probably more effective for reasons which cannot be strictly compared (that is, contact spread and accidental immunization). Thus, no one can say if the Sabin-type vaccine would have done better or worse!

On a "take it or leave it basis" with equal support and comparable educational and promotional campaign as offered the Salk vaccine, it is quite probable that a mass immunization with the live oral vaccine *would* definitely improve the situation appreciably as one example, by reducing the number of potential carriers of the wild, crippling strain in the community. Whether or not 75 per cent of the population would offer themselves to take the vaccine on a specified date, I cannot say. It depends on the acceptance of the program by the medical profession themselves and their ability to convey their recommendations to the community. Nevertheless, given a firm recommendation to do so from their own physicians, I feel more people would present themselves to swallow a sweetened solution of mongrel virus than to get injected hypodermically with anything regardless of how dead.

As to the statements concerning the blocking or interfering effect of Type II and Type III attenuated vaccine on establishing immunity to Type I, the published evidence seems to disagree with Dr. Bodian's position. It is more difficult to establish Type I immunity *at any time*, but establishing Type II and Type III before acquiring immunity to Type I would not doom the victim to everlasting susceptibility to the wild Type I infection. Successful immunization still can be done. It is more a problem of the size of immunizing or infecting dose at a propitious time.

In my opinion, there is one area of endeavor not receiving sufficient public attention pertaining to this problem. We are speaking of the efficacy of these vaccines from a statistical basis. We must devise practical economical, effective and reliable methods of determining which *individual* has been effectively immunized and which in-

continued page 356



HAWAII MEDICAL JOURNAL

Contents

Volume 21, Number 4, March-April, 1962

Articles

King-Anderson vs. Kerr-Mills, The Facts 327
Nancy T. Cabot, B.S.
What's Wrong with the King-Anderson Bill? 332
J. Alfred Burden, M.D.

Editorials

William Hillebrand, M.D. 340
Our "New Hat" 341
Social Security Medicine 341

Features

Book Reviews 348
Correspondence 301
County Society News 346
Hawaii Medical Association 350
In Memoriam—Doctors of Hawaii—XXXVII 345
King-Anderson—Kerr-Mills Comparison 338
New Members 347
Notes and News 349
Poison Report 342
President's Page 337
Reports and Snorts 321
This Is What's New! 343

Hawaii Technologists Bulletin

Ode to a Urinalysis Lab 354
Laboratory Findings Aiding in the Diagnosis of Untreated Pernicious Anemia 354

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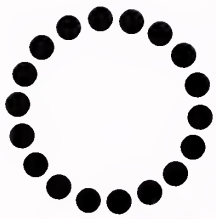
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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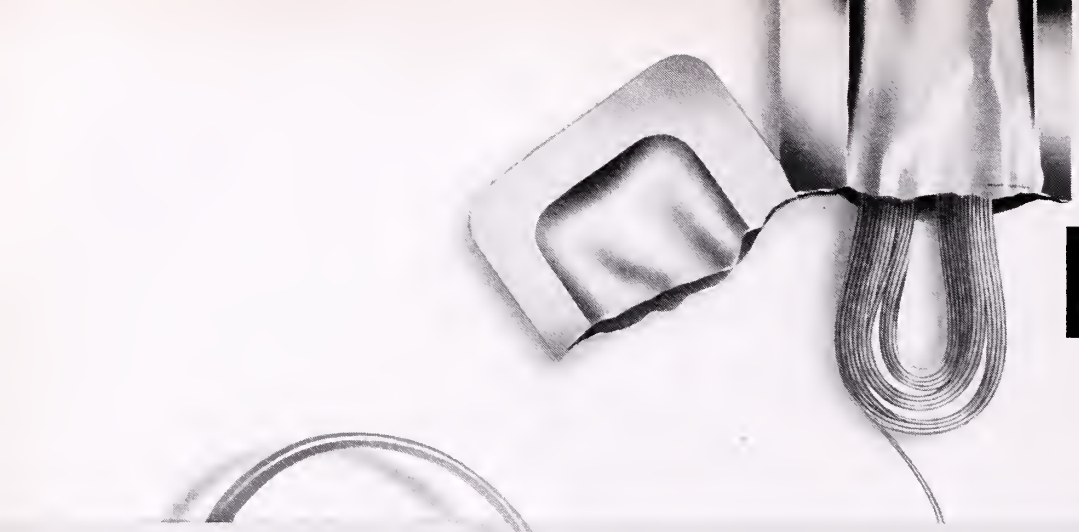
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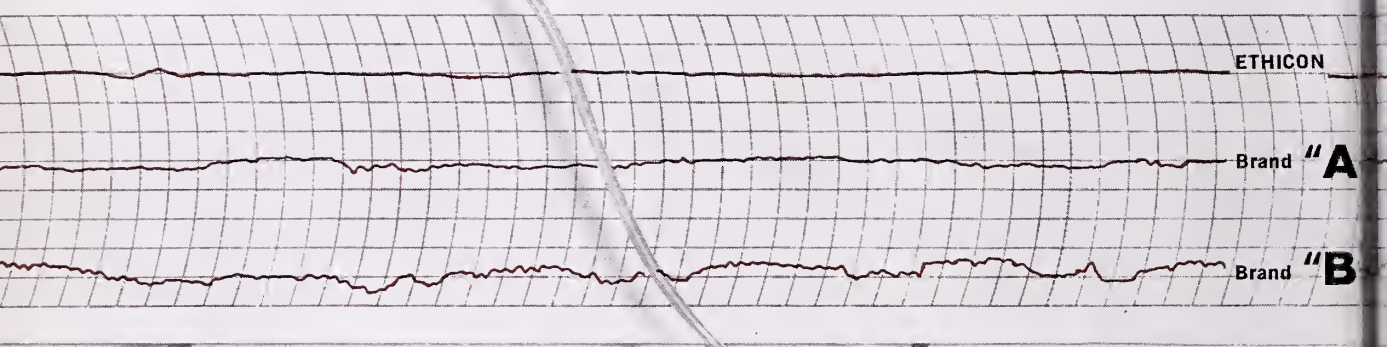
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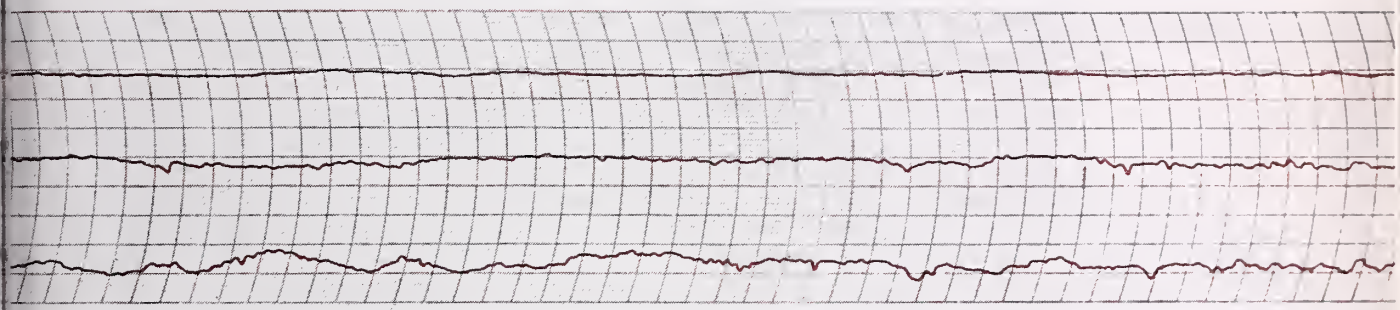


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References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. **2.** W. C. Breidenbach: Investigative clinical report, March, 1961. **3.** I. A. Feder: Investigative clinical report, May, 1961.

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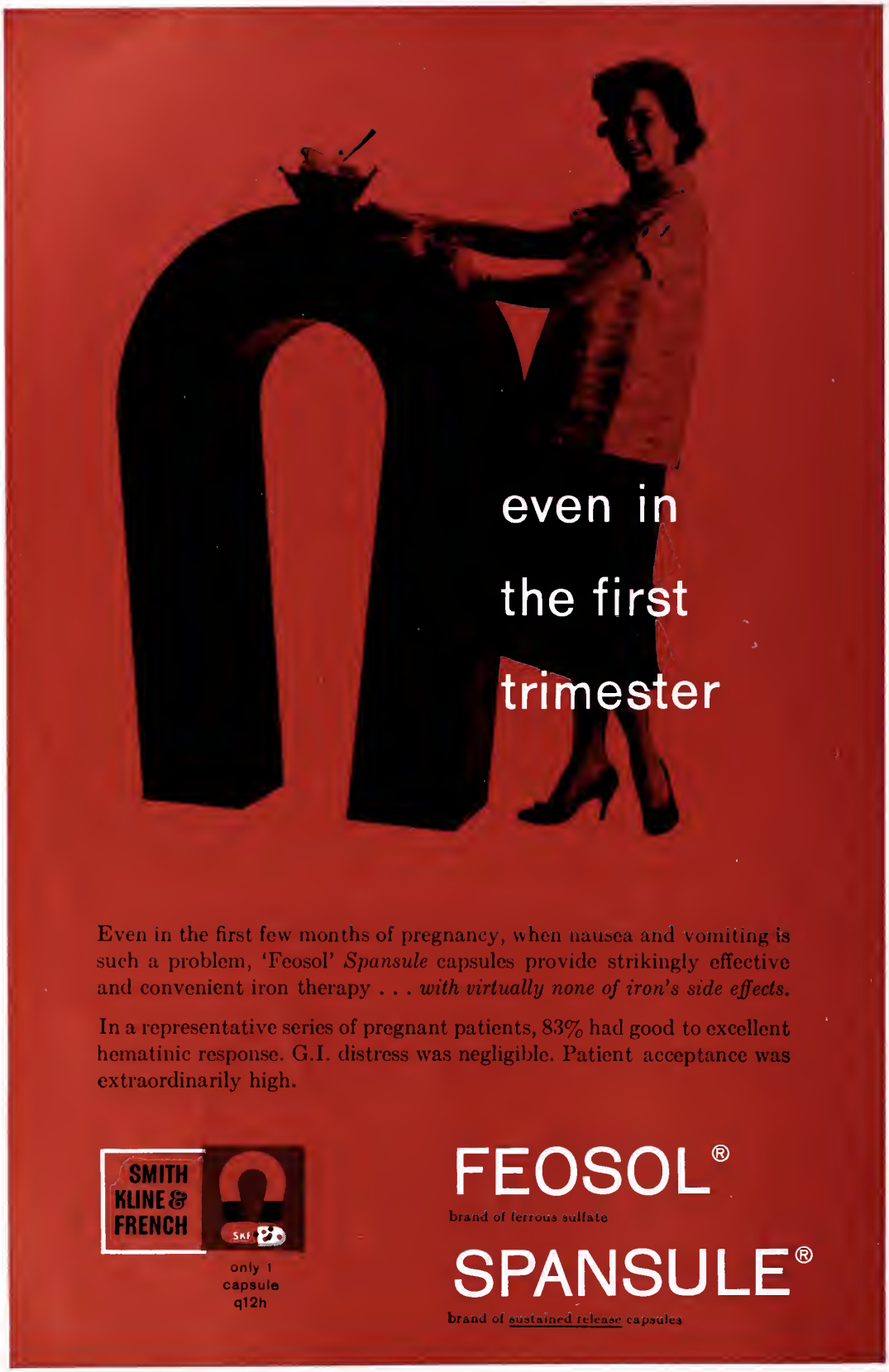
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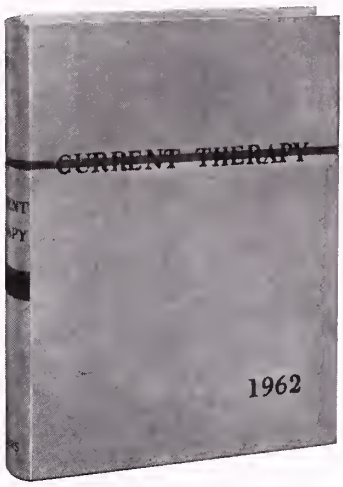
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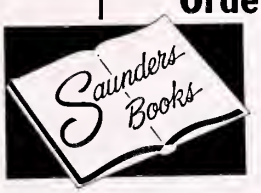
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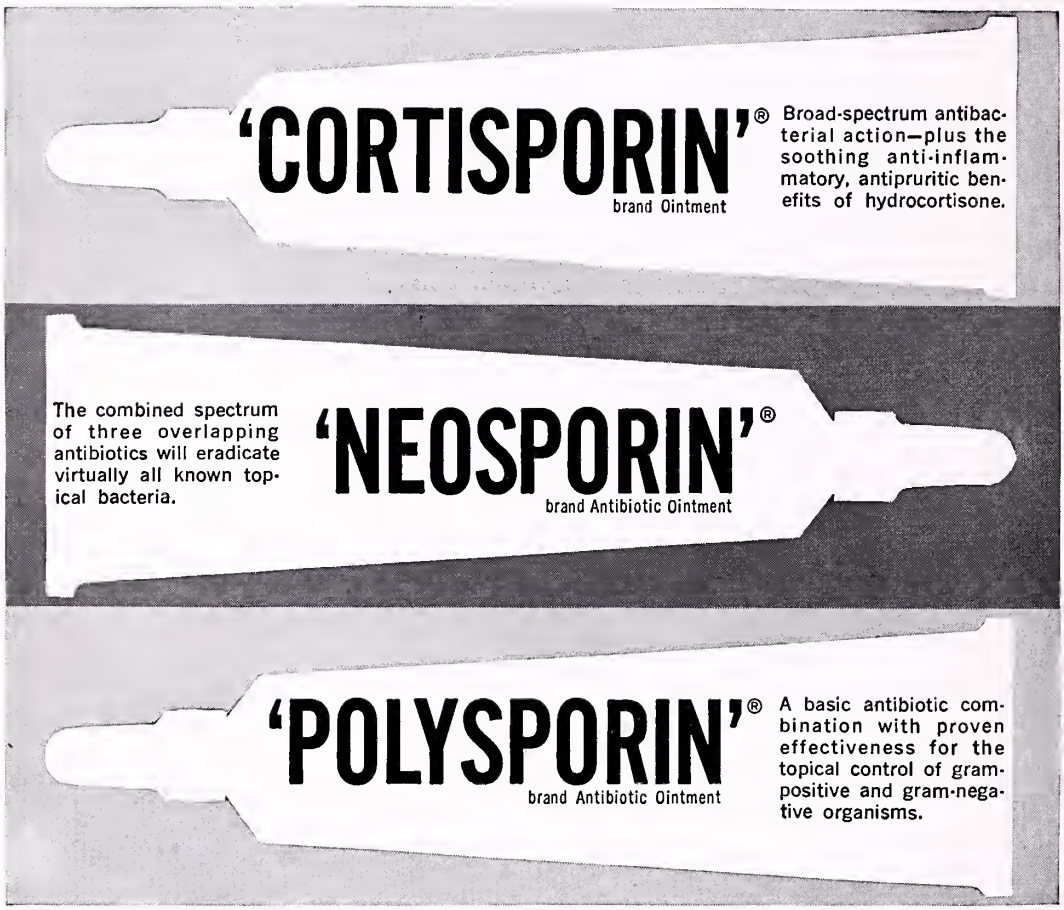


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Reports & Snorts

***Medical World News* reported in January that physicians can now practice as corporations in South Dakota, Minnesota, Arkansas, Wisconsin, Oklahoma, Florida, and Connecticut. In the states of Illinois, Ohio, Pennsylvania, Tennessee, Alabama, and Georgia, any professions can practice as associations, taxed as corporations.**

• • •

Convulsive therapy induced by an oral dose of ⅓ grain of strychnine (mistaken for quinine) apparently cured Mrs. Lucy G. Thurston in 1819 of complaints which may have been psychosomatic, according to a passage from her diary quoted by A. Wilmot Jacobsen of Buffalo in the *Journal of Neuropsychiatry* last fall.

• • •

Language can go to seed. Lesions cannot be red in anything but color, or few in anything but number: don't say, then, "red in color," or "few in number." Don't say "palms of the hands," either, or "soles of the feet." This is like saying "ears of the head," or "hands of the upper extremities." For that matter, don't say "upper extremities" unless you really mean *"arms* and *hands." Just say "arms."*

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I will fear no evil, for the Government is with me.
It prepareth an economic utopia for me
By appropriating the earnings of my own grandchildren.
It filleth my head with false security;
My inefficiency runneth over.
Surely the Government shall care for me all the days of my life;
And I shall dwell in a fool's paradise forever.

—ANON.

Reprinted from *Northwest Medicine.*

• • •

A mistress has been defined, not unreasonably, as something half way between a mister and a mattress.

• • •

The Department of HEW in Washington has asked several Honolulu citizens whether the University of Hawaii has a sense of institutional purpose; whether it should grow in size and scope; what is helping (and what hindering) it in achieving its goals and fulfilling its institutional potential. Is it possible that somebody might know these things?

• • •

In 1957, according to an editorial in *Pediatrics*, people in the United States spent $430,000,000 on vitamin concentrates and about $200,000,000 on medical education. The editor thought doctors should not prescribe vitamins so lavishly, but we doubt that the money thus saved would be spent on anything more useful than candy, cosmetics, or movies.

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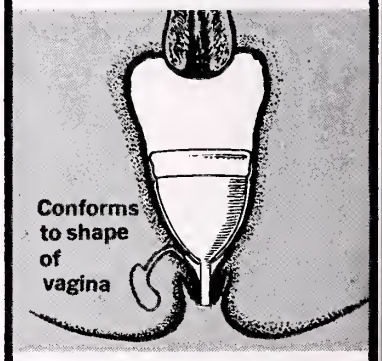
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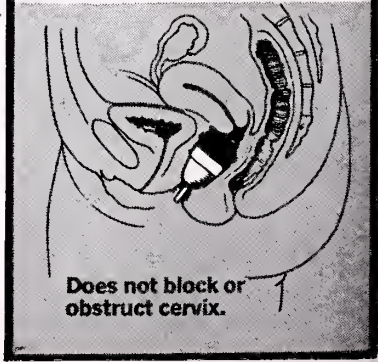
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You probably don't know all the provisions of the "King-Anderson" Bill

King-Anderson vs. Kerr-Mills

The Facts

NANCY T. CABOT, B.S., *Honolulu*

"THE high costs of medical care for the aged are going to be paid for in this country. The issue is not whether to pay these costs. The only issue is how to pay them." Thus Abraham Ribicoff, Secretary of Health, Education and Welfare, testified in behalf of the King-Anderson Bill, which would provide for payment for "hospital services, skilled nursing home services, and home health services furnished to aged beneficiaries" under a bill which is popularly but erroneously believed to provide medical care for the aged under Social Security.

Before we can evaluate the testimony presented at the hearings of the House Ways and Means Committee, we must first have a clear understanding of just what the proposed King-Anderson Bill is—what it proposes to do, who will benefit by it, and what its limitations are for the individual beneficiary. After this has been done, we can examine the proposed legislation to compare it with present programs of government-subsidized health care to determine if they are inadequate. Next, the financial aspects of both the proposed and present legislation can be considered. Finally, the dangers which are inherent in both the present and proposed legislation can be considered. To understand what follows, please turn to the center of the JOURNAL, pages 338 and 339, and study the chart which compares the provisions of the proposed King-Anderson Bill with those of the already enacted Kerr-Mills law.

IS THERE A NEED?

Before we begin to compare present to proposed health care legislation, we must consider the necessity of passing any health care legislation. Between the two extreme views of this subject—total government-controlled and subsidized health care for the nation, vs. no government-subsidized health care for anyone—there are a myriad of individual opinions and beliefs. But in this confusion of conflicting opinions, three incontrovertible facts emerge: more people are now living past 65; people over 65 are not as healthy as young people; and *some* people cannot afford the costs of adequate health care.

	U.S.	*Hawaii*
Median family income, all ages (1959)	$5,417	$6,366

In his testimony to show the need for the proposed bill, Secretary Ribicoff adds to these three facts a few opinions regarding the financial ability of oldsters to pay for their own health care. He begins by pointing out that 90 per cent of the people over 65 go to the hospital at least once, and goes on to say that the average length of hospitalization for persons over 65 is 2.3 days per year as compared to 0.9 days per year for persons under 65. He points out that their average annual income is $2,666, about half as much as for those under 65, and that their medical care costs are twice as high.

Later, when being questioned by Representative Curtis, he admitted that although the medical care costs of the aged are considerably higher than for younger citizens, their living expenses are also considerably less. Few persons over 65 are feeding, clothing, or educating a family. They purchased household durables such as appliances and furniture long ago. Because they lead more sedentary lives, their needs for food and clothing are considerably less than those of younger people.

Recent studies show that 62 per cent of all aged couples own their own home; 83 per cent of the homes are mortgage free. The majority of families whose head was over 65 had liquid assets in excess of $2,000, while the median income per family was nearly $3,000.

Some form of health insurance is carried by 53 per cent of the aged. They are hardly the indigents Ribicoff attempts to make them appear.

AVERAGE EXPENDITURES OF AGED

In his testimony, Ribicoff lists the average expenditures for medical care by an aged person during a year as $177. Of this, $55 is spent for physicians, $49 is spent for hospitals, $42 for drugs, $10 for dentists, and $21 for other expenses. Although it is impossible to determine how much more or less an individual would spend under the proposed legislation from his testimony, it is easy to see that the largest single expense is that of medical care by physicians, which is specifically excluded from this bill. When asked why, Secretary Ribicoff replied that the bill "reflects the philosophy of the President of the United States and this administration." Whether the bill was kept to such a minimum for political or economic reasons is certainly open to conjecture.

Type of Service	*Private Expenditure*	*Reimbursable by K-A*
Physicians	$ 55	0
Hospital care	49	$36.80
Medicines	42	0
Dental	10	0
Other medical	21	6.00
Total	$177	$42.81

In later testimony, Ribicoff stated that in analyzing the figures, the "fact" emerged that the basic problem of sickness is hospital cost, and in order to provide relief for the oldsters who couldn't afford to be sick, provisions were made to take care of the biggest cost—that of hospital care. This statement probably raises the question as to which *really* is the bigger cost—hospital care or medical care by a physician? Perhaps this can be answered by a conjecture. Twice Ribicoff makes the statement that people who have hospitalization insurance or higher incomes use the hospital more. Therefore, perhaps Secretary Ribicoff means that once many of these people think that their hospitalization will be fully paid for, they will use the hospital facilities more often. Then, of course, hospital expenses will be greater than medical expenses.

As part of his testimony, Secretary Ribicoff cites statistics to show the prevalence of chronic conditions among persons 65 and older. He states that 77 per cent of the persons 65 and over had one or more chronic conditions, and that 21 per cent had three or more such conditions. Arthritis, rheumatism, hearing impairments, heart conditions, high blood pressure, and visual impairments were the most common chronic conditions. Will government-subsidized health care eliminate these conditions? Consider again what is covered by the proposed legislation: hospital care, nursing home care, and home care—all on an extremely limited basis. It won't pay for glasses or hearing aids, it won't pay for medicine which will help the heart function more easily, or to relieve the pain of arthritis or rheumatism, or reduce high blood pressure unless the beneficiary is hospitalized. And yet, for the people—young and old—who need this medicine (or glasses or hearing aids) and cannot afford to pay for them, it would be a credit to the society in which they live if a mechanism were set up that would give them some financial relief for these aids to good health. But the need is not confined just to the old; 38 per cent of the younger population have chronic conditions, and since the average income of the working population is $4,700, it goes without saying that some of those under 65 cannot afford medical care.

	Over 65	*25–64*
Per capita income in U.S. (1958)	$1,030	$1,475

Number of Persons Over 65 in the United States

Date	*Total Population*	*Number Over 65*	*Percentage Over 65*	*Percentage Under 15*
1920	105,710,620	4,933,000	4.7	31.9
1930	122,775,046	6,634,000	5.4	29.4
1940	132,165,129	9,019,000	6.8	25.0
1950	151,325,798	12,295,000	8.2	26.9
1960	179,323,175	16,560,000	9.2	31.1

The fact that our society has medical indigents over 65, though, does not establish the need for relief from governmental sources. Rather, the fact that our society has indigents at all age levels, and medical indigents on many income levels, establishes this need. And any legislation along these lines should be evaluated as to how adequately it meets the financial needs of these indigents and medically indigents. Yet, the proposed legislation provides only minimum financial assistance for the aged and none at all for the younger population.

But what the proponents of the King-Anderson Bill are trying to say is that *all* persons over 65 are medically indigent and that all medical indigents over 65 are on Social Security. Fortunately, this is not the case. There are medical indigents. And because hospitals and pharmacists, physicians and dentists have no more personal obligation to carry the full financial load of these medical indigents than the local supermarket has an obligation to feed them or the city transit system has an obligation to carry them from place to place free, there is a need for financial assistance from government sources.

COMPARISON OF LEGISLATION

Evaluating the benefits of the Kerr-Mills Law is difficult, since it provides matching Federal funds for the individual states which implement it, and the extent of implementation varies according to the needs and finances of the states. The law has been in effect slightly more than one year, and

some 38 states have already made some provision to implement it. At this point, it is impossible to say if or how soon the remaining states will implement the Kerr-Mills Law.

Most implementing states provide at least the same benefits without, however, the deductible limitations specified by the King-Anderson Bill. In addition, prosthetic devices, such as glasses and hearing aids; physician's care and drugs both in and out of the hospital; and dental care are provided for under Kerr-Mills implementation. Hawaii's provisions are listed on pages 338 and 339 of this issue.

BENEFICIARIES

The beneficiaries under Kerr-Mills are not limited to the aged receiving Social Security. Each implementing state has established its own financial requirements, which are generally broken down into two categories: annual income, and assets, which includes real and personal property. In any implementing state, persons with income or assets in excess of a specified maximum are not eligible for benefits. (For more complete information as to financial requirements of each state, refer to page 162 of Secretary Ribicoff's testimony before the House Ways and Means Committee.)

Income. The average maximum income for a single eligible person is $1,553 per year. However, in two states, this figure may be more if the applicant shows that his needs (for previous bills, etc.) exeeed his income. The majority of the states limit personal annual income to $1,500. The avcrage income permitted for a married couple is $2,373, but again this figure can vary according to proven need.

Assets—Real property. In all cases, the home of the recipient is excluded from evaluation of assets, although Oklahoma limits the value of the applicant's home to $8,000. In all states except Massachusetts (where ownership of real property other than the home disqualifies an applicant) real property other than the home is taken into account in evaluating eligibility.

Assets—Personal property. Value of personal property an applicant may own also varies widely from state to state. Maryland excludes applicants with more than $300 in liquid assets apart from source of living expenses, and West Virginia permits a single applicant to hold $5,000 worth of personal property and this amount is increased to $7,500 for the married applicant. In almost all cases life insurance policies with a limited cash surrender value (ranging from $500 to $3,000) are exempt from consideration. Massachusetts excludes from benefits any person who has health insurance covering the services offered under Kerr-Mills.

IS PRESENT LEGISLATION ADEQUATE?

After we have studied the benefits and limitations of both the proposed and present legislation, we can begin to evaluate testimony as to whether or not the present legislation is so inadequate that it should be superseded by the plan to provide health care to the aged under Social Security.

One of the chief objections to the present legislation is that it requires a means test: that is, the person applying for benefits under this plan must show that he is unable to pay for the care he needs. Many people believe that the Kerr-Mills Law requires a person to be totally indigent before he may receive health benefits from the state, and that a person with assets, including his home, should liquidate all his assets before he is eligible to receive benefits.

A review of the requirements for eligibility will show that this is not true. True, the states do set maximum levels of assets, but this is to assure that funds will not be wasted on persons who might be able to pay for all or part of their care without any hardship to themselves. In order to implement any health legislation, standards must be established. One type of legislation requires that the beneficiary have limited financial resources; the other requires that the person be over 65 and eligible for social security. So the limitations on the beneficiaries cannot really be argued conclusively here because every person will have a different philosophy according to his own social conscience.

Another objection to the present legislation is that it has not been implemented in all the states, and that in those states in which it has been implemented, the benefits vary widely. Earlier, it was pointed out that the present legislation had been in effect only slightly more than a year. It is conceivable that during this year, there were elections, or short sessions of legislature, or other factors, such as their own system of medical care, which precluded passing such legislative action. An argument that Kerr-Mills is inadequate because it wasn't immediately adopted by all states is invalid because in the short time since it was passed, the majority of the states have taken some action towards implementing it.

It is true that the benefits provided under the Kerr-Mills Law vary widely among implementing states; this is evident from a study of the benefits provided by the various states. In almost every case, however, these benefits are in excess of those provided under King-Anderson. A good example of this would be the fact drugs and physicians' services are generally provided regardless of whether or not the beneficiary is hospitalized. The Kerr-Mills Law leaves matters up to the states by

Social Security Taxes from Inception of Program

Year Effective	*Payroll Deduction*	*Total Income Taxable*	*Maximum Payable* Per Year*
1937	1%	$3,000	$ 30.00
1950	1½	3,000	45.00
1951	1½	3,600	54.00
1954	2	3,600	72.00
1955	2	4,200	84.00
1957	2¼	4,200	94.50
1959	2½	4,800	120.00
1960	3	4,800	144.00
1962	3⅛	4,800	150.00

SCHEDULED RAISES IF KING-ANDERSON BILL IS *NOT* PASSED

(Already approved by Congress)

Year Effective	*Payroll Deduction*	*Total Income Taxable*	*Maximum Payable* Per Year*
1963	3⅝%	$4,800	$174.00
1966	4⅛	4,800	198.00
1968	4⅝	4,800	222.00

SCHEDULED RAISES AT TODAY'S ESTIMATE IF KING-ANDERSON *IS* PASSED

Year Effective	*Payroll Deduction*	*Total Income Taxable*	*Maximum Payable* Per Year*
1963	3¾%	$5,200	$195.00
1966	4⅝	5,200	222.00
1968	4¾	5,200	247.00

* This is the amount that is deducted from the employee's paycheck. The employer is also required to pay a like amount to OASI, which is considered one of the costs of doing business. The self-employed pays direct to OASI one and half times the amount the wage earner has deducted from his check.

giving them the right to set up their own programs under the assumption that each state is more aware of its own health care problems than the Federal government is. The legislators and health departments of the states which passed implementing legislation are not stupid; some study must have been made prior to determining what the basic requirements and benefits would be. And if a state, such as Kentucky, passes only minimum requirements and benefits, wouldn't it be logical to assume that this was done only after a careful review of the health facilities, financial resources, and needs of its inhabitants?

Take, for example, the provision in the King-Anderson Bill for skilled nursing home care. The bill provides a maximum of 180 days care in a home approved by the government. And, when testifying as to the need for government approval, Secretary Ribicoff stated that "ten per cent of the hosptials and 40 per cent of the nursing home beds are unacceptable because of fire and health hazards." The shortage of skilled nursing home facilities is a national problem. Hawaii, for example, has one nursing home (with 82 beds) to serve the needs of the entire state which would be accredited by the Federal government. So any law passed providing skilled nursing home benefits would certainly be of no use to the aged in Hawaii. And, with 40 per cent of the nursing homes in the nation considered unacceptable because of fire and health hazards, it is hardly likely that such benefits would accrue to many people in the United States. In evaluating the benefits provided by various states under the Kerr-Mills Law, this shortage of nursing home facilities should be considered.

Taking the two primary expenses of medical care, we find that the largest expense is not covered under the proposed legislation while it is provided for under the present legislation. We find that the King-Anderson Bill provides limited hospital and nursing home care while under Kerr-Mills only two states limit hospital stay and only one state limits nursing home care. Drugs are supplied by the majority of implementing states both in and out of the hospital, while under King-Anderson, drugs are supplied only in the hospital and in skilled nursing homes. Dental care is not provided for under King-Anderson.

The deductible amounts under King-Anderson can be no less than $20 per hospital stay and can be as high as $90, plus $20 for each outpatient clinic visit. Under Kerr-Mills, the patient who really cannot afford to pay for his medical care has nothing to pay.

King-Anderson provides extremely limited health care to everyone over 65 and on Social Security—poor and rich alike—while in most states Kerr-Mills implementation provides a full range of medical services for those who need it and can't afford it.

FINANCIAL ASPECTS OF THIS LEGISLATION

In order to finance the proposed program of health care for the aged under Social Security, Social Security taxes must be increased. In estimating the costs of the proposed program, the actuary for the Department of Health, Education and Welfare faced several problems: The number of eligible beneficiaries who would use the facilities provided, the rates of hospital admission, the average duration of hospitalization, the average daily per capita hospital charges, and the effect of this legislation on the use of facilities had to be considered on both a long and short term basis. After making what he considered to be adequate allowance for these variables, the actuary proposed that the earnings base be increased to $5,200, instead of the $5,000 originally provided for in the bill and that the tax be increased to 4¾ per cent of the payroll of both employer and employee. This is assuming that benefits would remain at the proposed level and that cost estimates would remain at the estimated level. Self-employed persons would pay 7⅛ per cent of their earnings. Under this plan, a trust fund would be established into

which would be deposited 0.65 per cent of the taxable payroll. Since revised cost estimates place the cost of these benefits at about 0.66 per cent of the total payroll, it is not hard to see that the fund will be running at a deficit, which will either mean that benefits will be decreased or that taxes will be increased. In view of the difficulty of discontinuing free services previously offered by the government, the latter seems more likely.

The average family income of the working population under 65 is $5,450 per year (vs. $2,666 for the over-65 group). The great majority of these people are attempting to feed, clothe, and educate a family. If the base earnings level is raised to $5,200, as is proposed, the majority of the population will be taxed without regard to spending power or dependents. However, Social Security rates have been scheduled to increase to 4⅝ per cent by 1968, even if the King-Anderson Bill is not passed. If the King-Anderson Bill is passed, the rate will increase to 4¾ per cent by 1968. Under the proposed increase, they would pay $247 per year in Social Security taxes. An employed man 20 years old today, will pay nearly $11,000 in Social Security taxes. At present, the maximum he would be able to collect is $127 per month, and the Social Security office does not anticipate any increase in this amount.

Hospital costs have more than doubled in the ten years between 1950 and 1960, and have more than trebled in the 14-year period since 1946. It is impossible to estimate what hospital costs will be twenty years from now. It is also impossible to estimate the increase in the use of hospital facilities by people who will be able to afford it, or the cost of providing government facilities to control the hospitals and to authorize payment for the use of their facilities. And yet, an attempt has been made to say that the costs will be this much and therefore the tax should be that much.

How much more realistic is the plan of the Kerr-Mills Law which provides that expenses for medical benefits to the aged be met through general revenue funds? For one thing, the expenses and their relation to the general revenue of the state, city, or county, are computed on a local basis. If a community needs more or less money to provide these benefits, the entire population of that community can be taxed according to their spending power (city taxes) and with regard to their income and number of dependents (state taxes). They are paying for what their own community requires. And the people in one state are not taxed because the people in another state cannot afford to meet the costs of taking care of their own.

	United States	*Hawaii*
Number of people over 65: Male	7,503,097	15,712
Female	9,056,183	13,150
Total	16,559,580	29,162

Local administration and local choice of scope of benefits mean that our tax dollars will be spent to best advantage. This approach guarantees that we will be helping those who really need help and that we will not waste tax dollars on those who are perfectly willing and able to care for themselves. We haven't passed any laws providing free supermarket privileges to those over 65 and under Social Security. If they need food and can't afford to buy it, their needs are met regardless of their age and regardless of whether or not they already receive some income from Social Security.

Why pass a law giving health care solely to these people? Some older people receiving Social Security have substantial property holdings and need to make a will to distribute it after their death. Shall we also pass a law to provide for payments to government-approved attorneys to help these people set up a trust fund or make out a will? If we pass a law providing for free shopping privileges, or legal advice, or medical care for one group, why not for another?

There are times when we have to use the government function to accomplish a result. But this should be done only when private methods do not move forward. At present, private methods are moving forward—more people than ever before have some form of health insurance.

According to Health Insurance Institute, 53 per cent of those over 65 have health insurance. And with new health insurance plans which provide a paid-up policy at the age of 65, and the efforts of labor unions in their collective bargaining to get increased retirement benefits including paid up health insurance for their workers, it is unrealistic to pass a blanket tax based on elusive cost factors which will provide minimum benefits to a limited group of people, not all of whom need it. ●

I have never been able to understand why the Social Security way would make sense, or why any working man would support it. It would multiply the tax collections and payments for medical care eight- or ten-fold, only to provide added funds to give to those who didn't need them.

Maurice H. Stans

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Here are specific and concrete objections to H. R. 4222, the King-Anderson Bill

What's Wrong with the King-Anderson Bill?

J. ALFRED BURDEN, M.D., *Haliimaile*

I am Dr. J. Alfred Burden, President of the Hawaii Medical Assoeiation. I have been engaged in the general praetiee of medieine on the island of Maui sinee 1939, except for five years of military service during W.W. II.

Hawaii, like most states of the Union, has been taking eare of its own and expeets to eontinue to do so, with some help from Federal funds—returned from taxes paid by the states.

HAWAII HAS A GOOD PROGRAM NOW

The Kerr-Mills Law, in effeet in Hawaii since July 1, 1961, has broadened the seope of help to persons over 65 by giving sueh Federal aid. On the basis of the first three months of experienee in operation of that Aet, physicians and health and welfare offieials of Hawaii are confident of its eontinuing sueeess.

Hawaii has long been alert to the needs of all its citizens in the field of health and medieal care. There is no metabolic change in a human being on his 65th birthday and Hawaii's attention has been given to the health of its people of all ages. There must be healthy ehildren in order to have healthy oldsters. The medical profession is interested in the people of all ages.

Hawaii, beeause of the dedicated interest of medical men, health and welfare offieials, and laymen alike, is on the way toward a balaneed total program in the field of chronic diseases. Hawaii's record in the eontrol of tuberculosis and Hansen's disease has attraeted national attention.

The Oahu Health Couneil, statewide in seope, is a catalyst in the field. The Governor's State Conferenee on Aging, held in 1954, resulted in intensified efforts to form a permanent organization in this field. The Committee on Aging and Chronie Illness of the Hawaii Medieal Association has been aetive sinee 1951.

The Hawaii Nursing Home Administrators' Assoeiation has improved the standards of nursing and nursing home eare. A state eonferenee on nursing home and care home administrators was held here last month. Our home nursing and industrial nursing services are outstanding.

Hawaii, through its Child and Family Serviee, its clinies, and its speeialized schools, ranging from institutions for retarded ehildren to a most modern rehabilitation eenter, is progressing toward the balaneed program we are working to perfeet.

Because of all this, the Hawaii Medical Assoeiation is disturbed over the threat to Hawaii's own voluntary health care program for people of all ages that is posed by a measure now before the Congress, H. R. 4222, the so-ealled King-Anderson Bill.

The Kerr-Mills Law, now in effect, affords praetieally unlimited medical, surgical, hospital, and other benefits to all aged persons who need help. The King-Anderson measure, with limited benefits, eompels eomplianee of all persons under Soeial Seeurity, regardless of need.

Operation of the Kerr-Mills Law, in eonjunetion with the rapidly expanding and improving system of voluntary health insuranee, renders needless a drastic approaeh to a problem whieh has not been shown to be drastie by proponents of the Social Seeurity approach.

KERR-MILLS LAW WORKING

Some statistics coneerning operation of the Kerr-Mills Act in Hawaii are applicable.

Latest estimates from the State Department of Health show the total number of persons in Hawaii who are over 65 years of age to be just under

* Statement of the Hawaii Medical Association presented at the Special Committee on Aging of the United States Senate hearing on Federal-State Activities in the Field of Health at Honolulu, Hawaii, November 27, 1961.

	1961 Civilian Population of Hawaii	Number on Welfare 1961	% of Total on Welfare
All ages	669,892	16,353	2.4
Over 65 years	29,162	1,472	5.2
Percentage over 65 (1960)	4.3%	11%	

30,000 (29,162), about 4.8 per cent of the total population. The national figure is 10 per cent. Last month (October) there was a case load of 1,249 persons over 65 years of age receiving financial assistance under the old age assistance category. This assistance includes food, shelter, clothing, and basic necessities, including medical care.

During the first three months' operation of the Kerr-Mills Act, July 1, 1961, through September, 1961, the State of Hawaii received 392 applications for medical assistance from persons over 65. Of these, 302 were approved. There were 66 rejections. These cases are being restudied to determine whether the policy governing grants should be made more liberal. None of these cases, which possibly do not fall into the area covered by the Kerr-Mills Act, have been neglected. All are receiving medical aid from other sources. All people in Hawaii have access to medical care, irrespective of financial condition.

Actual number of payments during the three-month period was 479. The total of such payments was $108,432. Of this amount the Federal matching share would be $57,791, or 53.38 per cent of the expenditure.

Based on this experience, it is believed the number of persons potentially eligible in this category will be about 1,200 during the fiscal year.

Under the new program, with Federal matching funds available, the State will be able to expand its program for the aged, which is the intent of the Kerr-Mills Act. In this respect it should be noted that U. S. states and possessions where the Kerr-Mills Act has begun to function this year in addition to Hawaii include Maryland, Massachusetts, Michigan, New York, Oklahoma, Virgin Islands, Washington, West Virginia, Idaho, North Dakota, Oregon, Louisiana, Maine, New Hampshire, California, Tennessee, Kentucky, and Utah. Only 18 state legislatures adjourned this year without taking some action toward implementation of the Kerr-Mills Act.

Although the program has merely begun in almost half the states, it is in successful operation. It is doing the job locally. It is getting help to the people who need help without jeopardizing the cash benefit program of the Social Security system.

With more facts and more experience, we can improve the program and continue to direct it locally rather than have the system made a part of the Federal government, directed from Washington.

We cite this as another example of locally directed effort in the field of health care which need not—must not—be controlled by the Federal government.

INDEPENDENT LIVING PROJECT

And we will mention also our Independent Living Project which is aided by Federal funds, but is controlled at the local level. This also is within the field of Federal-State activities with which this Special Committee of the U. S. Senate is concerned.

This enterprise bears a longer and more formal name. It is the program of Rehabilitation of the Chronically Ill in General Hospitals and Nursing Homes. The program covers young and old who need it.

We are rehabilitating not only the aged, but all individuals who become ill or handicapped. We are finding methods by which we reach patients early and put them on their feet when possible. We strive to treat such patients before their cases become irreversible. And at the same time we are trying to evaluate all hospital cases to the end that we may learn what types of cases may be benefited by certain programs and eliminate wasteful costs.

SPECIFIC FAULTS OF KING-ANDERSON BILL

Previous comment has dealt with general objections to the King-Anderson Bill as a measure that would take away individual enterprise and freedom, which proposes a Federally-sponsored program suited only to an impoverished society, and which would compel all eligible for Social Security, regardless of need, to participate.

Let us consider more specifically H. R. 4222, the so-called King-Anderson Bill, called by its table of contents the "Health Insurance Benefits Act of 1961."

While recognizing that the detailed provisions of any Social Security bill are immaterial in the long run, because the bill, if it becomes law, soon will be changed beyond recognition, we may yet observe that some of the provisions and statements in the measure are at variance with the facts, or with statements made by the President, who cannot be expected to examine all the details of such measures personally.

H. R. 4222 provides that the government shall collect taxes from employer, employee, and the self-employed. The Federal government subsidizes the program and issues the rules and regulations. The detailed provisions of H. R. 4222 are only of passing importance, but the principle which it would set up is of the utmost importance. That is no less than acceptance of the idea of social in-

surance medicine under the social insurance mechanism.

This is the mechanism used around the world as a legislative vehicle for the nationalization of medicine, whieh is a prerequisite to further nationalization of industry and the professions.

NO PROOF OF NEED

In considering some sections of H. R. 4222 individually, let us cite Page 3, Section 2, which says: "(a) The Congress hereby finds that (1) the heavy cost of hospital care and related health are a grave threat to the security of aged beneficiaries, (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs. . . ."

We answer that there is no proof that most of the aged beneficiaries are unable to afford private insurance adequately protecting them against the heavy costs of hospital care and related health care.

The facts, indeed, are quite to the contrary. Hawaii, with nearly 30,000 oldsters, expects only 1,200 applications for aid under Kerr-Mills during the fiscal year. And the Kerr-Mills machinery will take care of them.

GENERAL WELFARE NOT HELPED

Examine Page 4, Section 2(a)(4). This says: "It is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met through social insurance."

It is debatable whether "it is in the interest of the general welfare for financial burdens . . ." to be met through social insurance. We doubt that it is. Social insurance is the legislative vehicle for nationalizing medicine and has been so used in all countries having compulsory health insurance. In fact, the first social insurance law passed in Germany in 1883 was for social insurance medicine, that is, state medicine.

FREE CARE FOR THE UN-NEEDY?

On Page 4, Section 2(b)(line 17) is the statement that the purpose of the Bill is to provide medical service "in a manner consistent with the dignity and self-respect of each individual."

We would question whether any service provided by government, for which the recipient has made only token payment, is consistent with his dignity and self-respect as an individual unless he is financially embarrassed. The costs of these services will be covered—insofar as these are covered by Social Security taxes—largely by younger persons who are still working.

Any contributions paid in previously by recipients under this bill are obligated toward *present* benefits. These *new* benefits would have to be paid for by *new* money from people now at work.

The bill's statement concerning dignity is misleading.

FIRM CONTROL BY HEW

Equally misleading are lines 19-24 on Page 4 which assert there will be no interference with free choice of physicians and no exercise of Federal control over the practice of medicine by any doctor, or over the manner in which medical services are provided by any hospital.

This reference to noninterference is expanded in Section 1601, Page 5, which is not only completely misleading but can be characterized as double talk.

This states that there shall be no control over the practice of medicine or the manner in which the services are provided, but in line 23 it states: "Except as otherwise specifically provided." Since the bill does specifically provide for controls and for rules and regulations to be promulgated by the Secretary of the Department of Health, Education and Welfare, why is it asserted that there will be no supervision or control?

Completely misleading is Section 1602 on Page 6 of the bill. Part of this section has been quoted for public consumption. The conclusion has been drawn that patients will have freedom of choice. But the section clearly states that the patient will have freedom of choice only among those providers of services who have made an agreement with the government to provide such services. The patient is limited to such providers. Further, when rules and regulations are written there is likely to be some geographical restriction. Patients presumably would not be allowed to go to providers of services at any great distance from their homes.

MANY PHYSICIAN SERVICES COVERED

Continuing examination of H. R. 4222, we call attention to Page 7, Section 1603 (a)(4) providing for certain exclusions of services. The Kennedy administration has insisted that the government will have no control over physicians. Yet, this section specifically states that the hospital services for which the government will pay will exclude medical and surgical services provided by a physician, resident, or intern "except in the field of pathology, radiology, physiatry, or anesthesiology, and except services rendered in the hospital by an intern or a resident-in-training under a teaching program approved by a recognized body approved for the purpose by the secretary. . . ."

That covers varied services by physicians. These

presumably would be paid a salary by the hospital. Such salaries would be included in the negotiated costs to be paid by the government. They would be a part of the government contract and would, to that extent, be a part of nationalized medicine.

"DEDUCTIBLE" FEATURE

Page 10, Section 1604 lists the deductible features of the plan. While we are in favor of the deductible feature, we should like to point out that this has not been publicized. The public is probably unaware of the limitations here provided.

And does the public know that care in hospitals is limited to 90 days? Does the public know nursing home care is limited to 180 days?

Turning to Page 14, Section 1606(a)(7) we note a blanket provision which puts a hospital at the mercy of the Secretary of Health, Education and Welfare. He is authorized to make "such certain other conditions of participation in this section as . . . (he) may find necessary. In a word, the Secretary may promulgate any conditions that he sees fit, even though they might be considered unwarranted interference.

And on Page 20, Section 1608(b) we find more than an implication that the HEW Secretary could set up his own hospital accrediting body. Could he?

PHYSICIANS OUTSIDE HOSPITALS INVOLVED

Page 21, Section 1609 (a)(2) deals with certification and recertification by physicians. The certification of OASI beneficiaries will require a considerable amount of a physician's time. Is he to be paid? If he is, will not this draw him into the Federal program? Further, this section states that the physician, in filling out the certification for hospitalization initially, and for continued stay in the hospital, must make his decisions on the basis of Federal regulations (line 16). This involves all physicians with patients who seek these benefits and who are eligible for them. The whole tenor of Section 1609(a) involves the physician with patients seeking these several forms of service with the responsibility of deciding what services are needed and how long they are needed. This involves the professional services of the physician, contrary to the expressed statement of the bill referred to earlier.

"REASONABLE" COSTS

Page 23, Section 1609(b) refers to determination of the costs of services which, it is stated, must be "reasonable." Who is to say what are the "reasonable" costs for which the HEW Secretary will pay? Who is to decide how they are to be determined? It is specifically stated that "regulations" shall provide the method or methods of determining costs. It is further to be noted that regulations "may provide for the use of estimates of costs of particular items or services." This covers a great deal—costs of drugs, salaries to be paid to physicians working in hospitals, salaries for nurses, and other items.

Number of persons in Hawaii over 65 on welfare	1,472
Number of persons in Hawaii over 62 (women) and 65 (men) on Social Security from own account	16,508
Number of persons in Hawaii over 65 receiving no support from State or OASI	11,182*

* This is an approximate figure since OASI benefits may be collected at age 62 by women.

Progressing to Page 28, Section 1611, we call attention to the fact that the Secretary has great discretion in the reduction of payments if funds are scarce. This has been done in other countries.

ADVISORY COUNCIL—WHO WOULD BE ON IT?

Section 1612, Page 29, provides for a Health Insurance Benefits Advisory Council of 14 persons to be appointed by the Secretary. Four of these shall be persons "outstanding in the fields pertaining to hospitals and health activities" (Line 20). One might be a physician, one a hospital administrator, one a dentist, one a nurse. But even this is uncertain. Who would the other ten be? This should be spelled out.

On one hospital advisory council, appointed by the Federal Security Administrator before there was an HEW Secretary, one of the appointed members was Michael M. Davis, the leading lobbyist for the nationalization of medicine.

Membership of the council should be specified in the bill. Even so, if the members are appointed by the Secretary, they must be responsive to him. There should be provision for appointment of members of professional organizations including the AMA, ADA, ANA, AHA, the American Pharmaceutical Association, and others. There can be an objectionable loading of representatives including, even, lobbyists for nationalization.

FULL FEDERAL CONTROL

Concerning regulations, we call attention to Section 1615 on Page 31 of H. R. 4222. This says: "When used in this section the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary."

This is a key provision that gives Federal control, for these regulations have the force of law.

Since these regulations are not written until the providers of services have signed up, these providers are making a blind date with fate.

FINANCING VAGUE

This measure also implies that the integrity of the separate trust funds now existing (OASI and Disability) will be lost. The expansionist move in setting up a "Federal Social Insurance Trust Fund" —something new—is the key here. This is to have three accounts, one for OASI, one for Disability, and one for Health. But note that all the money now present in the two funds now existing, OASI and Disability, are to be merged and transferred to the over-all Federal Social Insurance Trust Fund.

Does this mean that if one account is in the red it can get help from another account? The public is entitled to clarification.

SIX-FOLD RISE IN TAX!

Note well that there will be a six-fold jump in the tax on employers and employees after the first year, a fact that has not been adequately publicized.

Page 37, Section 706(e)(1) provides that the tax on employers and employees shall be 0.1 per cent the first year but goes to 0.6 per cent the second year, six times as much. The self-employed person would pay 0.075 per cent the first year and 0.45 per cent the second year, also a six-fold increase. There is no indication of what the tax hike will be after that, also a point that should be specified now. It could be a warning to those who blindly embrace a plan controlled by "regulations" issued by a single individual.

Study carefully and note that the Managing Trustee, that is, the Secretary of the Treasury, may invest any funds which are left over in government bonds at the going rate of interest. This is under terms of Section 706(g), Page 39. Most important, he may put up, as collateral, bonds made especially for investment by the Trust Fund (Page 30, line 9).

And on Page 37, Section 706(e)(1) we learn that the wage base is to be increased to $5,000.

This is part of the upward climb predicted by Wilbur J. Cohen when he testified at his nomination hearing.

We have gone into detail concerning a few points of H. R. 4222 because we have seen nothing in the record concerning these discrepancies and misstatements.

THE CAMEL'S NOSE?

We will end this by making a brief comment on Section 402, Page 67, which we consider of paramount importance.

This section authorizes the HEW Secretary to study (3) "the feasibility of providing additional types of health insurance benefits within the financial resources provided by this Act."

This is a customary method of authorizing fishing expeditions into the field of compulsory health insurance. It opens a wide field of exploration.

And since we don't know what the financial resources will be after such a program gets going, and taxes are increased, the Secretary could make practically any kind of "study" he wished.

He could even experiment with additional services under compulsory health insurance.

If this bill were enacted into law there would be an immediate clamor for more benefits for the aged, for a lowering of the eligibility age limit, and for payment of surgical fees.

Beyond doubt the younger workers, who would be compelled to pay the taxes and receive no benefits, would insist that as long as they were paying taxes for hospital benefits for the aged they should share in those benefits.

Within a decade, perhaps less, there would be a full program of medical care under Federal control.

COMMENTS AND CONCLUSIONS

Abuses, soaring costs, and general inefficiency of that system can be examined in England today. Nationalized medicine has become expanded there to complete welfare statism in which America need not become embroiled so long as the individual states care for their own needy and the majority of the people continue to take care of themselves.

We call attention to the fact that this calls for limited hospitalization, not general care, and that it is not likely that our hospitals on Molokai and Lanai, or our small plantation hospitals could qualify.

The bill would give limited help to 70 per cent of those persons, rich and poor, who are under Social Security, but would give nothing to the 30 per cent who can never qualify no matter how poor and destitute they may be.

Gentlemen, we don't want guidance by remote control when we are doing so well by ourselves—without compulsion for all for the benefit of a few who are being taken care of already.

In conclusion we urge:

1. That the states be allowed to continue to operate under the Kerr-Mills Law, which gives almost unlimited benefits to all, until the full potential of that law is realized.

2. That H. R. 4222, a limited, dangerous, compulsory approach to nationalized medicine, be rejected as unbecoming to the American people.

The Hawaii Medical Association thanks this committee for the opportunity to be heard. ●



The President's Page



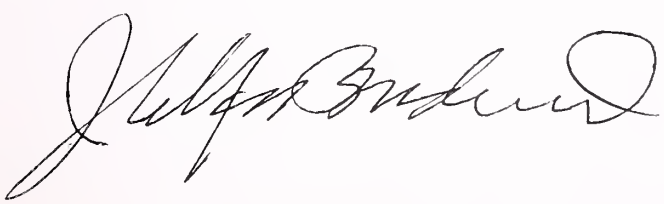
The clash between the "far rights" and the "far lefts" has caused so much smoke it has left us "in between folks" completely confused. This has caused a situation that is fraught with two dangers. First, those of us who are inclined to be on the conservative side might be inclined to throw up our hands and do nothing. The other danger is that under cover of the confusion the moderate leftists, or those inclined towards socialization of everything, will take advantage of the "let's have nothing to do with the mess" attitude of the moderates in order to get their socialization bills through.

This is a real danger, for once a law socializing something is passed, it is next to impossible to get it changed. This emphasizes the importance of our actively fighting against the passage of the King-Anderson Bill as well as the bill for Federal aid to education, in itself an attempt by the Federal Government to gain control of our educational system, and all other bills promoting increased Federal control of those things which should be left to the states and to local communities. If the Federal Government is able to control the educational system and the medieal system it will not be long until the other segments of our society will also be under Federal control. There are those who feel that socialization is a defensc against communism, but many who have studied the situation assure us that socialization is rather a step toward communism.

Be that as it may, we all must realize that with socialization and the centralization of power and controls in the Federal Government we will certainly lose our individual rights and freedoms for which our forefathers fought and the principles which have been the firm basis on which our nation was built and its greatness established. One only has to note the great loss in world prestige the United States has suffered since World War II, as a result of the trend away from these principles, to realize in which direction we are headed. This is paralleled by our loss in prestige as physicians on the national scene, brought about to a great degree by the determined efforts to socialize medicine. Our position is precarious, but it is not too late if all physicians will realize the seriousness of the situation and dedicate themselves to the two-fold proposition of fighting to preserve their right to practice medicine on a free enterprise basis and to striving to make the best possible medical care available to every one on a voluntary basis. We must back our voluntary medical plans to the utmost and see that they are made available to every segment of our society, or the Federal Government will be dictating to us whom we shall take care of and what kind of care can or must be provided.

This issue brings you the details on the King-Anderson Bill and the Kerr-Mills Act. Read the material over and familiarize yourself with this information so that you can discuss the problem intelligently with your patients and with others; so that you can know how to help implement the Kerr-Mills bill to help make it a success; and so that you will know what to do to help defeat the King-Anderson measure.

See you on Maui in May!



King-Anderson v

	KING-ANDERSON (Social Security)	KERR-MILLS (Federal-State Grants)
Hospital Benefits		
Room and Board	Up to 90 days†	No limit
General Duty Nursing	While in hospital	As needed
Private Duty Nursing	None allowed	On recommendation of physician
Attending Physicians' Services	None allowed	Staff physicians in Honolulu or Government physicians in rural areas
Resident and Intern Services	While in hospital	While in hospital
Pathologist, Radiologist, Anesthesiologist Services	While in hospital	As needed
Physical, Occupational, and Speech Therapist Services	As allowed by hospital	OP & PT on inpatient or outpatient basis; no speech therapist services in present program
Medical Social Services	As allowed by hospital	Where available
Drugs		Allowed on either inpatient or outpatient basis
Other Services and Supplies Necessary to Health	Allowed if the hospital or skilled nursing home usually provides such services	As needed
COST TO PATIENT	$10 a day or $90.00 maximum, $20 minimum	No payment required of patient
Outpatient Hospital Benefits		
Diagnostic Services	Services and supplies customarily furnished by hospital to outpatients in approved hospitals only for purposes of diagnostic study, excluding any service not customarily furnished to inpatients of the hospital	As needed
Physicians' Services	Not covered unless furnished by an intern, resident-in-training, pathologist, radiologist, anesthesiologist, or physiatrist if generally furnished by hospital	As needed regardless of specialty
Drugs	Not applicable	As needed
COST TO PATIENT	$20 for each diagnostic study	No payment required of patient
Physicians Services		
Home and Office Visits	None allowed	Government physician's services in rural districts. In Honolulu outpatient hospital visits
COST TO PATIENT	Entire physician's bill	No payment required of patient
Home Health Services	Patient must be under care of physician	No limitations
Room and Board	None allowed	Allowed in care homes
Visiting Nurse Services	Subject to combined 240 unit* maximum	If needed
Physical, Occupational, and Speech Therapist Services	Subject to combined 240 unit* maximum	As needed except for speech therapists, which are not included in program
Medical Social Services	Subject to combined 240 unit* maximum	If needed
Drugs	Not allowed	As needed

* 1 unit = 1 visit by an occupational therapist, physical therapist, visiting nurse, speech therapist, or medical social worker.

Mills in Hawaii

	Hospital Benefits KING-ANDERSON	KERR-MILLS (Federal-State Grants)
·sing Home Care	180 days care† per benefit period after having been transferred from an approved hospital (per benefit period) provided the patient has not been in the hospital more than 60 days	Not limited
ıtal Care	None	As needed except for dentures
ıefit Periods	After receiving benefits, the patient cannot receive further benefits until 90 days have elapsed after discharge from hospital or nursing home	No interruptions in service required. Patients receive continuous services as long as needed
ɛctive Dates for Receiving Benefits	One year after enactment	July 1, 1961
ʂpital Eligibility	Must meet the specifications set forth by the Secretary of HEW. In addition the hospital must (1) be primarily engaged in providing specified services, by or under the supervision of physicians or surgeons, (2) maintain adequate medical records, (3)have bylaws in effect with respect to its staff of physicians, (4) provide 24-hour service by registered nurses, (5) have a hospital utilization committee, (6) be licensed by local law, and (7) meet such other conditions as the Secretary of HEW may find necessary.	Any hospital licensed in Hawaii
ʳsing Home Ɛligibility	Must meet the specifications the Secretary may find necessary and (1) be primarily engaged in providing skilled nursing facilities or rehabilitation services, (2) have medical policies established by a group consisting of at least one physician, (3) be under the supervision of a physician or registered professional nurse, (4) every patient must be under the care of a physician, (5) provide 24-hour nursing service rendered or supervised by registered nurses or licensed practical nurses. (6) operate a nursing facility utilization plan.	Any nursing home licensed in Hawaii
ient Eligibility		
ıge	Must be 65 or over‡	Must be 65 or over‡
ocial Security Benefits	Must be receiving Social Security benefits	Social Security benefits not necessary
ɛarned Wages	Earned Wages cannot exceed that amount which would exclude recipient from receiving Social Security benefits	Earned wages allowed if insufficient to enable applicant to pay for medical care
ncome Other Than Earned Wages	No restriction	Allowed if insufficient to enable applicant to pay for medical care
ıssets	No restriction	Limited; i.e., applicant is considered eligible if residence has a tax evaluation of not more than $14,000

nit = 1 day in a hospital or 2 days in a skilled nursing home. Limit: 150 units combined hospital and nursing home care.
iefits are not automatic under the proposed King-Anderson Bill or the now operating Kerr-Mills Law; applicant must make written
l uest for benefits.

HAWAII MEDICAL JOURNAL

Editorials

William Hillebrand, M.D.*

I estimate that this is about the 100th time that this society or its counterpart has had an annual meeting. The first charter is dated July 19, 1856. The first record of an annual meeting of the Hawaiian Medical Society is dated December 8, 1858. Thereafter, meetings were held irregularly. The Honolulu County Medical Society came into being in 1925 when, at the urging of the secretary of the A. M. A. and local physicians, the Territorial Medical Association and its component societies were started.

The first signature on the beautifully handwritten charter is that of William Hillebrand.[1] He was the secretary at the first annual meeting in 1858. I find no mention of his holding other offices in the Society, but presume that he did. This Titan of a man has long been my hero, and I believe he was the greatest of all Hawaiian physicians. His accomplishments and deeds have on occasion been told by others, but I do not believe he has been given proper acclaim in our medical society.

William Hillebrand was born in Prussia in 1821. He was educated in Goettingen, Heidelberg, and Berlin. After graduation from Berlin, he practiced a few years in Paderborn near his birthplace, until illness, presumably tuberculosis, forced him to seek a more healthful climate. He sailed to Australia, then to the Philippines. In Manila he practiced for a time, and then illness induced him to sail again, this time to San Francisco and later to the Hawaiian Islands, arriving here in 1851. He was then 30 years old and remained in Honolulu until 1871.

Others in the Honolulu medical fraternity were Dr. T. C. B. Rooke, who had married a daughter of John Young and his high chiefess wife, and Dr. S. Peter Ford, who started the rice-growing industry in Hawaii. Also there were Gerrit P. Judd of the missionary family, Wesley Newcomb, Edward Hoffmann, B. F. Hardy, and G. P. Lathrop. All of these signed the charter.

Hillebrand married the daughter of Dr. Newcomb and began collecting trees, flowers, and shrubs for his home. This interest he pursued for 20 years. He traveled to all of the islands, penetrated the deepest ravines, and scaled the highest peaks to collect specimens. This interest in botany led to his monumental manuscript, "Flora of the Hawaiian Islands." This is still an invaluable aid to botanists.

Hillebrand was sent by the Commissioner of Immigration in 1865 to Malaya, China, and India. He arranged for the importation of the first laborers, mostly Chinese; and while there investigated means for control of leprosy. He is credited with diagnosing the first case of leprosy in Hawaii. In 1877 he arranged for the emigration of workers from Madeira and the Azores.

For many years he was the corresponding secretary to the Royal Hawaiian Agricultural Society and arranged for the introduction of desirable seeds, such as the monkeypod and the royal palm. On his travels in Asia he sent back plants, trees, animals, and birds. We are indebted to him for most of the flowering trees and ornamental plants. The remaining trees on The Queen's Hospital grounds, and those at the Agricultural Station at King and Keeaumoku Streets were planted by Hillebrand. His home was at Nuuanu and School Streets. This is now Foster Gardens. It was he who planted the magnificent trees there.

Hillebrand was the first attending physician at The Queen's Hospital, and I assume he was in charge. He was physician to the royal family. It is recorded that on May 20, 1858, he was in attendance when a son was born to the Queen. He was on the staff of the Insane Asylum, and a very active member of the Board of Health. He was a member of the Privy Council of King Kamehameha V, and the king's private physician. He was a fine musician and father.

This is but a summary of this great man's life, but on this night for the installation of officers I thought we might honor him. It will help us all to know and to remember that our Society had great men as founders.

DOUGLAS B. BELL, M.D.

* Read before the Honolulu County Medical Society's annual meeting, December 5, 1961.

[1] HAWAII MED. J. 15:314 (Mar.-Apr.) 1956.

Social Security Medicine

Father Stanley Parry, Professor of Political Science at Notre Dame, finds the King-Anderson Bill wrong and unsound both in detail and in principle, and has said so in his testimony before the Ways and Means Committee of the House of Representatives. Following is his summary of his presentation:

RESUME

H. R. 4222, proposing to extend the provisions of social insurance to relieve medical indigence among the aged covered by social security, raises three issues: two of them are basic to the matter of the bill, the third is basic to the modern problem of legislation.

The first issue is whether the facts of medical indigence among the aged warrant abandoning the principle currently followed in offering medical relief, that of the local marginal relief of proven individual indigence. The bill proposes a new principle, that of Federal preventive intervention to protect predefined classes of people from indigence. Experience with difficulties over marginal relief show that a change from it is warranted only when new causes of indigence are proven, when these causes are in their nature permanent and perduring, when they will clearly and predictably affect a class of people. The statistical evidence offered in support of H. R. 4222 fails to prove a new condition among the aged, a new cause of indigence, therefore it cannot give a convincing reason for the proposed change in principle.

The second issue is whether H.R. 4222 offers insurance against illness and not rather a system of earmarked taxation for the relief of the aged ill. If it is in fact a taxation plan, then the bill will not only fail to relieve the general revenues, as it claims it will, but in fact will increase the burden on them. If a tax plan, and therefore a plan for free medical aid, the bill will result in the artificial inflation of fancied illness and so not lighten the burden on medical facilities but result in a waste of them. It is clear and has been judicially recognized that the social security process is rooted in the taxing power and is not an insurance process. Finally, the bill could hardly reduce the burdens of welfare work when it proposes to aid all the aged ill and not merely the proven indigent. It simply transfers the burden to the willing shoulders of the Federal Government, and in the transfer augments it.

The third issue involves the estimate of the bill from the point of view of the mentality motivating it. The principle of marginal relief considers misfortune an exception and a tolerable success the rule in American society. The principle of preventive intervention considers medical indigence among the aged a permanent affliction of the aged, and for all the aged. It rejects the evidence of progress, the socially elaborated techniques of insurance, pensions, savings, and the like. Its fundamental postulate is fear and discouragement. Since there is no convincing evidence for such a position, and since the available evidence concerning earnings, distribution of wealth, the condition of the aged suggests improvement, it follows that the bill is rooted in a sheer option to solve the problem of medical indigence on the basis of a fearful view of the future. In this age of anxiety, we ought not legislate anxiety into our very legal system.

In brief, he finds the Social Security, King-Anderson approach wrong on four specific grounds: (1) The aged are by no means all indigent or medically indigent; the program is *logically* unsound; (2) the program is not one of insurance but one of increased taxes, paid not by its beneficiaries but by younger wage earners; the plan is *fiscally* unsound; (3) the plan is rooted in anxiety, fear, pessimism, and discouragement; it is *morally* unsound; and (4) the plan, by making hospital and nursing-home care "free," will inevitably and enormously increase the amount of utilization of such care, in preference to ambulatory or office care: it is *medically* unsound.

Our "New Hat"

The *Hawaii Medical Journal* and *Inter-Island Nurses' Bulletin* is no more—long live the HAWAII MEDICAL JOURNAL! With this issue we are on our own, and with this issue we are putting on a "new hat."

The new cover, in a more modern style, gives us space to indicate featured items in each issue. It was designed by Alec Baird Associates.

The text type face has been changed from Garamond, 11 point, to Times Roman, 10 point on an 11-point body. Bodoni bold is used for most boldface in the text and for most headings.

No old features have been dropped, except for the nurses' section. A new one has been added. "Reports and Snorts" is in the front advertising section and contributions for it are invited. County minutes are no longer reported verbatim, and following the condensed county reports are pictures of their new members.

Brief Reports On Poisoning

For the past four years, the Poison Control Center at Children's Hospital has offered an invaluable poison information service to physicians. In addition, the Center has recorded many interesting cases of poisoning which have come to our attention. In many instances, therapy has been initiated promptly upon our recommendations.

Through the collection and interchange of data from the experiences of the Center, the attending physicians, and hospital personnel, the Poison Control Center plans to publish in the HAWAII MEDICAL JOURNAL *outstanding cases of poisoning occurring in Hawaii. It is hoped that this information will help to devise means for better prevention and more efficient treatment procedures.*

RICHARD K. B. HO, M.D., *Director*

Asterol Dihydrochloride Toxicity

CASE REPORT

This 14-month-old female infant was admitted to a local hospital in July, 1961, because of convulsions over a 10-day period. She had become very lethargic and stumbled frequently when walking. There was depigmentation of the skin in the areas in which, for the past several months, the patient had received treatments with Asterol tincture for a diaper rash thought to be due to Candida albicans.

The drug was promptly discontinued during the hospitalization and progressive improvement was noted.

DISCUSSION

The toxic properties of Asterol dihydrochloride (2-dimethylamino-6-[beta-diethylaminoethoxyl]-benzothiazole dihydrochloride) have been sporadically reported in several articles.

The compound is a well-known effeetive fungicide used in the treatment of dermatophytoses, especially tinea capitis.

According to some reports, prolonged use has occasionally resulted in neuropsychiatric disorders, characterized by convulsions, hallucinations, muscle twitching and weakness, tremors, incoordination, listlessness, exaggerated reflexes, rolling of the eyes, and ataxia.

As in the previous cases reported, it is difficult to establish a causal relationship between the local application of Asterol dihydrochloride and the observed neurotoxic properties.

Nevertheless, these cases should be given careful consideration, and precautions on the use of this medication as advised by the manufacturer and in the previous case reports are justified.

Fortunately, neurotoxic effects of Asterol occur rarely. In addition, prompt discontinuance of treatment in patients where these effects are noted is followed by progressive recovery.

Strict regard should also be given to medications which are generally not advised for children. ●

TREATMENT

1. Prompt discontinuance of the medication.
2. Supportive measures.

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Ananase: a Proteolytic Enzyme from Pineapples

Hawaii's first medical product went on the market last month: Ananase, a mixture of four bromelains extracted from pineapple stems, where they are 30 times more abundant than in the fruit. These bromelains are proteolytic enzymes, like trypsin, and they rapidly depolymerize and destroy fibrin and permit its removal from areas of inflammation. They have the advantage of being only one-sixtieth as active against fibrinogen as trypsin is, and also of being (since they're of plant origin) much less expensive. Preliminary medical trials suggest that Ananase will be useful in the same situations—virtually all sorts of traumatic or infectious inflammatory lesions—as trypsin. It is administered orally, in 50,000-unit enteric-coated tablets. Rorer manufactures it, from Dole's raw material.

This is What's New!

● Editors of journals that usually concern themselves only with medical matters have recently discussed the implications of **thermonuclear war.** The editor of *Lancet* (Sept. 2, 1961) asks "Has mankind a future?" and wonders whether man can avoid "disastrous dissolution by the misapplication of his own ingenuity."

In the November *Annals of Internal Medicine* the editor considers further the question raised by his British colleague. He turns to the human cortex to solve the possibility of thermonuclear nightmare. "To do this, the cortex must win out over the thalamus. The hand that lovingly fondles the machine-gun now loads the missile and fondles the countdown button. The dream animal with human brain had better break the habit and break it soon or the sweet dream will fast become a nightmare."

And still in the month of November, the radiologist, R. R. Newell, writes "I'll say that I'm not now talking about shelters and developing an underground culture. I'm talking about operating on our human culture and extirpating international warfare. I'm talking about willfully divesting ourselves of our garments of priceless purple—our sovereignty, or at least enough of it so that workable international decisions can be made and acted on whether we believe the decision just or not. We today are sentimentally tied to the American way of life and unable, apparently, even to explore the possible roots of migration into another way of life that might make future life on earth definitely indefinite instead of indefinitely definite—I mean finished." (*Stanford Medical Bull.* [Nov.] 1961.)

● Israeli physicians reviewed 40 cases of **pseudomembranous enterocolitis** that came to autopsy. Analysis of the clinical data revealed that all cases had either shock, anemia, heart failure, hydrothorax, or an inflammatory pulmonary condition. They suggest **hypoxia** as the common denominator. The histologic picture was essentially identical in all cases, with superficial necrosis of the gastrointestinal mucosa being the most obvious change. (*Gastroenterol.* [Oct.] 1961.)

● "The instillation of various exogeneous pigments into the dermis," which is the way the *New England Journal of Medicine* describes the ancient art of **tattooing,** has been **outlawed** by New York City Board of Health. The reason given by the Board of Health is that tattooing transmits **viral hepatitis.** This may be true, but we suspect that there was an unmentioned aesthetic reaction that crept into the Board of Health's decision. (*New Eng. J. Med.* [Dec. 14] 1961.)

● Two forms of **progressive muscular dystrophy** have spectrophotometrically **abnormal myoglobins.** This discovery suggests that muscular dystrophy may belong to the "molecular diseases of Pauling" or the "inborn errors of metabolism of Garrod" or perhaps "the inborn errors of molecular structure of Garrod & Pauling. (*New Eng. J. Med.* [Dec. 21] 1961.)

● A new phenothiazine derivative, **methotrimeprazine,** given by injection, is as potent as morphine, mg for mg, in the **relief of pain.** Given by mouth, it is no more effective than a placebo. (*J.A.M.A.* [Dec. 2] 1961.)

● Since its discovery 25 years ago, the polypeptide **angiotensin** has greatly interested investigators of hypertension. A recent symposium on angiotensin indicates that subcutaneous or intramuscular injection of the substance produces a consistent **rise in the blood pressure of patients in shock.** It has been found to be as effective as norepinephrine and in some instances useful where norepinephrine failed. (*Circulation* [Jan.] 1962.)

● Determining of the **prostatic fraction of serum phosphatase** after digital palpation of the prostate may confirm the suspicion of **carcinoma of the prostate.** The test may be of special value where carcinoma is strongly suspected but the serum acid phosphatase is normal. (*Journal of Urology* 86:442-449 [Oct.] 1961.)

● **Routine EEG tracings** prove to be the best way of **detecting insecticide poisoning** among workers in a plant where the potent insecticide Aldrin is made. The appearance of bilateral synchronous theta-wave activity in a worker with previously normal EEG was felt to be evidence of clinical or subclinical toxicity and the worker was removed from contact with the insecticide. (*Environmental Health* [Jan.] 1962.)

● Investigators in Philadelphia and Minneapolis report on their experience with the anticancer drug, **5-fluorouracil.** Conclusion from Minneapolis: 5-fluorouracil is most effective in breast cancer with a limited role in "the treatment of selected patients with advanced breast cancer not responsive to hormonal therapy." From Philadelphia, "toxicity (diarrhea, leukopenia, and alopecia) may be severe" and the "drug is a dangerous one to use but it does have a **definite though limited** value in the therapy of certain malignancies of man." (*Ann. Int. Med.* [Nov.] 1961.) ●

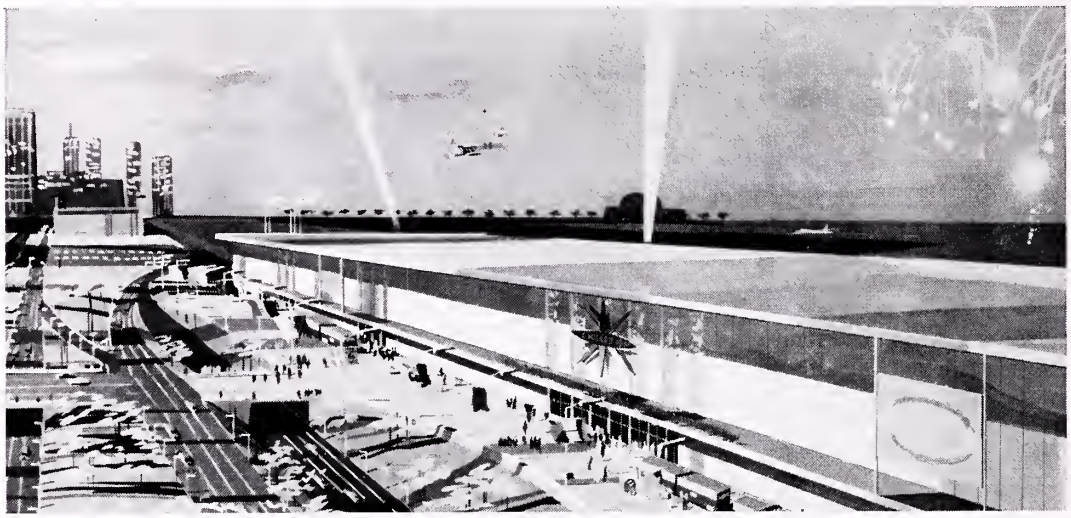
FRED I. GILBERT, M.D.

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In Memoriam - Doctors of Hawaii
XXXVII

This is the thirty-seventh installment of In Memoriam—Doctors of Hawaii.

John Williamson Palmer

John Williamson Palmer was born April 4, 1825, at Baltimore, Maryland, the son of Edward and Catherine (Croxall) Palmer. His medical degree was granted by the University of Maryland in 1847.

From 1849 to 1850 Dr. Palmer was the first city physician of San Francisco. Arriving in Honolulu January 4, 1851, aboard the "Lydia Ann" from San Francisco, the doctor opened an office the following month. He practiced in Honolulu for several months but left later in the same year to become surgeon of the East India Company's war steamer, "Phlegethon," which gave him the distinction of being the only American who ever held a commission in the East India Company's "navy." From 1851 to 1852 he served in the Second Burmese War, presumably in the service of the same company, and returned to the United States in 1853.

Settling in the East (probably Baltimore), Dr. Palmer engaged in literary work as well as medicine. From 1855 to 1856 he wrote a series of papers covering the period from 1849 to 1850 for *Putnam's Magazine* and the *Atlantic Monthly*. He also contributed articles to *Putnam's Monthly, Atlantic Monthly,* and *Century Magazine* about his experiences while traveling in the Hawaiian Islands, China, Burma, India, and other eastern countries.

In 1855 Dr. Palmer married Miss Henrietta Lee, also an author.

During the Civil War, Dr. Palmer served with General John C. Breckenridge (Secretary of War in 1865) in the Virginia valleys and in the War Department of the South. He was Confederate war correspondent of the *New York Tribune,* writing under the nom de guerre of "Altamont," and made a unique and important contribution to the field of journalism. In 1870 the doctor moved from Baltimore to New York and became a member of the editorial staff of the *Century Dictionary* and of the *Standard Dictionary*.

On February 26, 1906, Dr. Palmer died at his home in Baltimore at the age of 80.

He was distinguished as a physician, traveler, litterateur, and poet. His literary works include *Stonewall Jackson's Way,* a spirited camp song, translations of Michelet's *L'Amour* and *La Femme* and other works, and compiling *Folk Songs* and *Poetry of Compliment and Courtship*. He was the author of *The Golden Dragon; or Up and Down the Irrawaddy, The New and The Old; or California and India in Romantic Aspects, The Queen's Heart* (a comedy), *After His Kind* (a novel), and *The Beauties and Curiosities of Engraving,* and many others. Perhaps the doctor is best known for his lyrics and heroic ballads which include *For Charlie's Sake, Theodora, The Maryland Battalion,* and *The Fight for San Jacinto*.

Holmes Fielding Troutman

Holmes Fielding Troutman was born in Calhoun, Ga., on April 15, 1881, the son of James Holmes and Mary Victorine (Walker) Troutman.

His academic education was received at Mercer and Auburn Universities, and his M.D. was granted in 1908 by the University of Pennsylvania School of Medicine. He interned at Philadelphia General Hospital.

In 1910 Dr. Troutman arrived in Honolulu to become chief surgical resident at The Queen's Hospital. In May, 1911, he went to Hawaii to succeed Dr. Collins at the Pepeekeo Central Hospital. He remained at Pepeekeo until 1914 or 1915 when he returned to the mainland.

Dr. Troutman was licensed to practice in West Virginia in 1926, locating at Glen Rogers. Thereafter he practiced at Page, Logan, Bradenton, Florida, and Huntington, West Virginia. In 1944 Dr. Troutman retired from active practice and made his home in Huntington.

The doctor was married and the father of a son, Holmes Russell, and two daughters, Mrs. Joanna Fernstermacher and Mrs. Florence Ettling.

Dr. Troutman died at Huntington on August 16, 1955, at the age of 74.

While in the Islands, he was a member of the Medical Society of Hawaii from 1911 to 1914. At the time of his death he was an honorary member of the Fayette County Medical Society, the West Virginia Medical Association, and the American Medical Association.

County Society News

Hawaii

At the last 1961 meeting the following officers were elected: Pete Okumoto, President; Robert P. Henderson, Vice President; Ruth Oda, Secretary; and Nicholas Steuermann, Treasurer.

At the first 1962 meeting the membership voted to donate $500.00 to the University of Hawaii, Hilo Campus Library, in memory of Dr. Toshio Kutsunai. Dr. Wipperman presented a critique of the recent medical evacuation exercises on which Dr. Richard K. C. Lee commended the group. Dr. J. A. Burden, HMA President, was present for his annual visit and addressed the society on the problems of the King-Anderson Bill and voluntary insurance.

The February meeting was held at the Hilo Hotel on the 10th. Dr. James Mitchel was thanked for representing the society at the Career Day Program held at the Hilo High School. The AAPS Essay Contest will not be sponsored by Hawaii County this year. It was voted to continue to waive the dues of Drs. Asami, Luce, and Griggs. Dr. Paul J. Caldwell was welcomed into the society. Dr. Shizuto Mizuire was appointed to represent Hawaii on the newly created state Plans and Adjustment Committee. Dr. Oglesby Paul addressed the society on coronary diseases.

Honolulu

At the November 7, 1961 meeting a film entitled "Carcinoma of Rectum & Sigmoid Colon" was shown, followed by a talk on the same subject by Dr. Frank F. Albritten. Members were asked to donate medical equipment to the dispensary of the Church College of Hawaii. New members Keith Kuhlman, Francis Terada, and Benjamin Tom were welcomed into the society. A change in the bylaws was voted which requires that Honolulu members of the HMSA Board of Directors elect one of their number as their floor leader, provided that the chairman of HMSA's Medical Committee is not a member of the society, to make the monthly report to the Board of Governors. Another bylaw change empowers the Board of Governors to act for the society in selecting any panel of physicians for nomination to the Board of Directors or physician committees of HMSA. Units were established for open-heart surgery and three otolaryngology procedures. The membership approved the Board of Governors' action in accepting the request of HMSA to increase their surgical fee schedule to a 4.5 conversion factor using the 1957 RVS of the society. The president noted that the HMSA has been advised that the rate does not reflect the present private practice fees in this area. Nominations from the floor were made for the coming election.

The annual meeting was held on December 5, 1961, and approximately 230 members were present. Drs. Casimer Jasinski and Harold Y. Nekonishi were welcomed into the society. A resolution that the Honolulu County Medical Society go on public record as stating emphatically that the American Medical Association does represent its will and desires, and that the present AMA leadership enjoys the full confidence and support of the entire membership, was passed. Bylaw changes altering the make up of several committees were accepted. The following officers were elected: Drs. Theodore T. Tomita, President-elect; B. Allen Richardson, Secretary; and Robert T. Wong, Treasurer. Newly elected regular members of the Board of Governors were Drs. Bernard W. D. Fong, Unoji Goto, Robert Katsuki. Alternate members elected were Drs. Richard Horio, Charles S. Judd, Jr., and Chew Mung Lum.

The first 1962 meeting was held on January 9, 1962, as a joint meeting with the Hawaii Bar Association. The program consisted of a film entitled "A Matter of Fact," which dealt with forensic pathology, and a discussion on the medical and legal aspects of the office of the Medical Examiner. Speakers were Dr. Alvin V. Majoska, and Mr. Robert C. Dodge. Dr. John J. Lowrey moderated. New member John F. Burnett was welcomed into the society. The president announced that Drs. Bernard Fong, W. F. Moore, Unoji Goto, John Ohtani, John Lowrey, and W. H. Wilkinson were selected to serve as the Review Committee for the Federal Employees Medical Plan. The HMSA advised that the fees recommended for open-heart surgery and three otolaryngology procedures had been accepted as a guide. The society went on record as accepting as its fee schedule the current relative value schedule of the Honolulu Foundation for Medical Care, with a conversion factor of 5.00 across the board. Dr. Marnie reported on his ad hoc committee's meetings with the Public Utilities Commission in an effort to come up with a form for truck drivers' examinations. A discussion followed on the extent of this examination and the appropriate fees. Each doctor was asked to use his own discretion in setting his fee. Generally speaking, it was felt that this would probably run from about $10.00 to $12.50.

Kauai

The December 6, 1961, meeting was held at the Wilcox Memorial Hospital library. Dr. Boyden reported on his committee's meetings with the county Board of Supervisors regarding medical fees for county pensioners. The following officers were elected for 1962: Drs. Marvin A. Brennecke, President; William W. Goodhue, Vice-President; and Vernon G. Boido, Secretary-Treasurer. Dr. Peter Kim advised that the Department of Health's Mental Health Division will sell at cost psychiatric medications which have been recommended by the visiting psychiatrist should these not be available. The coming poliomyelitis vaccination program was planned. One injection only of Salk vaccine will be given to anyone under 18. It was recommended that doctors give the inoculations in their districts.

Maui

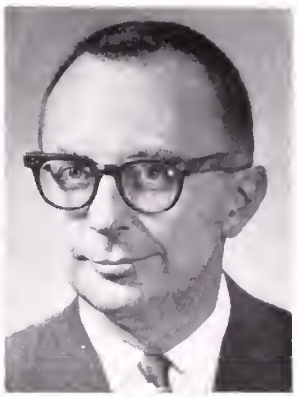
The final 1961 meeting was held on December 19. New bylaws were unanimously adopted. Dr. Guy Heder was elected to membership in the society.

111th AMA MEETING • CHICAGO, JUNE 25-29

New Members



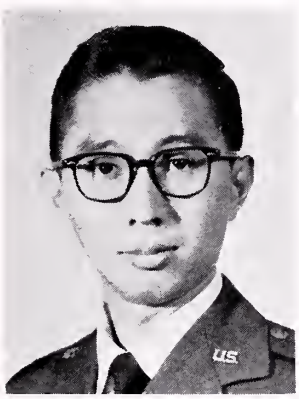
Paul J. Caldwell, M.D.
P. O. Box 606
Hilo, Hawaii
Obstetrics
Temple University, 1950
Internship—Passauant Memorial Hospital, Chicago



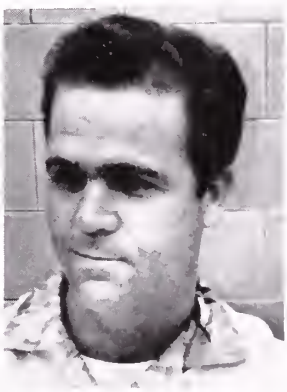
John F. Burnett, M.D.
Room 7 Aiea Super Market Bldg.
Aiea, Oahu
General Practice
Washington University, 1953
Internship—Seattle General Hospital
Residency—San Francisco Kaiser Hospital



Casimer Jasinski, M.D.
Department of Health
Honolulu, Hawaii
General Practitioner
Washington University, 1957
Internship—The Queen's Hospital



Harold Y. Nekonishi, M.D.
1481 So. King St.
Honolulu 14, Hawaii
Pediatrics
Washington University, 1956
Internship—St. Luke's Hospital, Chicago
Residency—St. Louis Children's Hospital



Guy Heder, M.D.
Kaunakakai, Molokai
General Practice
Temple University, 1956
Internship—Southern Pacific Hospital

Book Reviews

★Problems in Surgery

By Frank Glenn, M.D., 512 pp., $16.50, The C. V. Mosby Company, 1961.

THIS BOOK has presented in a very succinct manner a stimulating and fascinating variety of surgical problems, pointing at the same time to the enviable wealth of material at the New York Hospital. The opinions of such experts as Steinberg on angiography, Holman on thoracic problems, and Glenn and Wantz on porto-biliary surgery are always informative. The section on esophageal surgery, in particular, is invaluable.

But, because of its format and coverage, the volume obviously could not be as detailed in any one field as De Takats in vascular or Naclerio in bronchopulmonary diseases. However, the approach is as refreshing and entertaining as "Current Surgical Management" and the "C.P.C.'s" of the *New England Journal of Medicine.*

This is an excellent and interesting addition to the library and a volume that all surgeons aspiring to be well informed should peruse.

WALTER Y. M. CHANG, M.D.

★Blood Diseases of Infancy and Childhood

By Carl H. Smith, M.A., M.D., 572 pp., $17.00, The C. V. Mosby Co., 1960.

DR. CARL SMITH has written a textbook which should become a classic in the library of all physicians who are dedicated to the care and welfare of children. Dr. Smith is a recognized leader who has helped unravel the many hematologic problems of infancy and childhood throughout his professional career. He has been an inspiring teacher and a leader in clinical and laboratory research dealing with the causes and treatment of various blood diseases of the pediatric age group. This book, therefore, is written by a real pioneer, a scholarly man who has great experience as a pediatrician, as a hematologist, and as a teacher in the field of pediatric hematology.

The chapter on transfusions in the pediatric practice is well written and is excellent in reiterating the limitations and hazards of transfusion and giving true, nearly precise, indications for transfusions.

The chapter on iron deficiency anemia has a wealth of information in the metabolic considerations of iron and iron therapy. His descriptions of many types of hypoplastic and aplastic anemia is a valuable contribution and his great understanding of thalassemia, or Cooley's anemia, is brilliantly documented in the chapter on Hereditary Hemoglobinopathies.

The chapter on blood coagulations brings to the clinician a clearer understanding of some of the problems involved in the defects due to the deficiency of plasma factors in the blood and outlines methods of testing for the various phases of coagulation.

An excellent feature of this volume is the size of the bibliography. This itself will serve as an excellent text for any physician involved in the care and the treatment of hematologic problems of children.

This book is recommended for all physicians: pediatricians, hematologists, the generalists, and the internists. With the rapid advances that pediatrics and hematology are undergoing, in all probability, the book will require future revision to continue to bring up to date this classic work. It is the hope of the reviewer that Dr. Carl Smith will have the scholarly energy to give us future revisions of this book.

RICHARD E. ANDO, M.D.

★ Means highly recommended.

★Anatomy

By Ernest Gardner, M.D., Donald J. Gray, Ph.D., Ronan O'Rahilly, M.Sc., M.D., 999 pp., $15.00, W. B. Saunders & Co., 1960.

THIS BRIEF textbook of anatomy does not include extraneous information. It provides information and stresses the relationship between the structure and function of the body. Three-dimensional views of a single region are provided. The important words are written in italics.

The new international standard anatomical nomenclature is used in this book. This volume is highly recommended for physicians who need a quick, concise, and simple book to refer to in anatomy.

WALLACE W. S. LOUI, M.D.

★Care of the Well Baby—Medical Management of the Child from Birth to Two Years of Age

By Kenneth S. Shepard, M.D., 224 pp., $3.25, Lippincott Co., 1960.

DR. SHEPARD has written a book that should be valuable for medical students, interns, and new pediatricians in practice who are suddenly confronted with the responsibility of helping new parents begin the life of enjoying the new baby that they have acquired. This book is, in many respects, a book on "how-to-do-it" for the young physicians who are interested in developing techniques in giving parents reassurance, understanding and some anticipatory guidance.

The reviewer recommends this book for all new physicians who are confronted with the responsibility of the care of infants and the counselling of new parents. It is the hope of the author that the reader will gain some motivation in providing some anticipatory guidance to the parents of their infant patients, thereby making life more enjoyable for the child and for the parents.

RICHARD E. ANDO, M.D.

The Compleat Pediatrician, 8th Ed.

By Wilburt C. Davison, M.A., D.Sc., M.D., and Jeana Davison Levinthal, B.A., M.D., 257 pp., $4.50, Duke University Press, 1961.

THE 8TH EDITION has been face lifted and improved, with additions of newer concepts and knowledge of antibiotics, anticonvulsants, antihistamines, steroids, and electrolytes, and deletions of many obsolete pediatric theories and disproved facts. Paucity of detailed descriptions and discussions found in standard pediatric textbooks is compensated by a condensed cream of pediatric information. It is truly a handy reference for the busy general practitioner and pediatrician.

H. Q. PANG, M.D.

★Clinical Hematology, 5th Ed.

By Maxwell M. Wintrobe, M.D., Ph.D., D.Sc. (Hon.) 1186 pp., $18.50, Lea & Febiger, 1961.

REGARDED AS A STANDARD TEXT in the relatively unexplored field of hematology since its appearance two decades ago, this monumental work has the distinction of being the most complete source of information on this subject in existence today. Frequent revisions have kept pace with the rapid developments in hematology and its ancillary disciplines. The author's continuing, active interest in this field is reflected in the erudite treatment of new discoveries

continued page 374

Notes & News

Congratulations to . . .

Dr. Gail G. I. Li—as director of Travel House, a new travel agency.

Dr. Richard K. C. Lee, who submitted his resignation as Director of the State Health Department to accept a position at the University of Hawaii as a full professor—good luck, professor!

Dr. Leo Bernstein, who will succeed **Dr. Lee** as the Health Department Chief.

Dr. Lawrence H. Winter, who succeeds the late **Dr. Frank Glaser** as chief of the alcoholism branch of the State Health Department.

Dr. T. Nishigaya sneaked in an engagement announcement of his daughter to get publicity. The daughters of **Drs. Shizuto Mizuire** and **William Bergin,** both of Hilo, are also listening to wedding bells.

Dr. George F. Schnack, new director of Child and Family Service.

Travel News

Seen in L.A. at the Inter-American Conference on Congenital Defects were **Drs. Clifford Kobayashi, Wallace Loui, Donald Poulson, B. Allen Richardson, Fred Shepard, David Pang,** and **Ruth Oda.**

Dr. George Ewing attended the Regional Conference of Public Health Officers in L.A. He spoke on "Health Facilities in Hawaii."

Names in the News

After 38 years of practice, **Dr. Lyle G. Phillips** has taken down his shingle. A trip around the world is in store for him and Mrs. Phillips, after which he will settle down to a much deserved rest doing the things he wants to do—good luck, Lyle!

The latest HMA TV production, "What's in a Picture?", highlighted **Drs. Calvin C. J. Sia, R. G. Rigler, William F. Moore, Jr.,** and **Grover J. Liese.**

Dr. Edward Boone, Chairman of the Oahu Emergency Medical Service Committee, gets increasingly deserved recognition for his committee's work on Civilian Defense.

Dr. Sam Tashima made news the hard way. He stumbled and fell at a local hospital and was in serious condition with a head injury.

The recent visit of **Dr. Morris Fishbein,** former editor of the *JAMA*, was the cause of a round of entertainment. **Dr. G. F. Straub** and **Dr. F. J. Pinkerton** did the honors.

Dr. Fred Gilbert's excellent photograph of a fire-destroyed research building was published in the *Star-Bulletin.*

During the recent eclipse of the sun, **Dr. O. D. Pinkerton** cautioned the public to use dark sun glasses to minimize injuries to the eye.

Dr. W. A. Myers' recent survey of Hawaii youths' allergic disease rate showed higher incidence of certain conditions.

Dr. Al Burden's comments in rebuttal to Jack Hall's address to ILWU Pensioners Association were in good taste and very apropos. Ditto his remarks to the Waikiki Rotary on the Kerr-Mills vs. King-Anderson Bills.

Drs. James and Robert Wong lost two brothers in a cesspool accident.

Dr. C. F. Chang stuck his neck out for ex-delegate J. A. Burns. He heads a "Citizens' Committee"—Burns for Governor. Also associated in this group are **Dr. Duke Choy** and **Dr. Cesar B. DeJesus.**

As President of the League of Women Voters of Honolulu, **Dr. Tern Togasaki** reminded citizens of their duties.

Dr. Hastings Walker, in Leahi Hospital's annual report, said, "There is some reason to believe that the incidence of active tuberculosis (in Hawaii) has been increasing"—this was the cause of a S-B editorial asking the community to meet the challenge. As a result, State health authorities have formed a committee, headed by **Dr. Ira Hirschy** and **Dr. Robert Marks,** to review TB control and treatment programs.

Dr. Linus C. Pauling, Jr. (Director, Mental Health Clinic at Queen's) had to do some fast talking when a

continued page 356

WILLIAM HERBERT WYNN
1891-1961

William Herbert Wynn was born in Campbellton, Florida, February 13, 1891, son of William Baker and Dora Whittaker Wynn. He was educated at Jackson County High School, attended the University of Florida from 1909 to 1912 and received his M.D. degree from Tulane University in 1916.

Dr. Wynn interned at the Charity Hospital, New Orleans, from June, 1916, to February, 1917. During World War I Dr. Wynn served as an officer of the medical corps of the U. S. Navy. Following the war he remained in the Navy as a flight surgeon from 1922 to 1925. He attended the U. S. Army School of Aviation Medicine in 1922, and was the first naval flight surgeon on Ford Island at Pearl Harbor. He married Miss Alice De Leseo in 1924. They had three children, William Baker, Miles Pratt, and Jane. He resigned from the Navy in 1925 to enter private practice in Honolulu. He was first associated with Dr. Charles B. Cooper and Dr. Clarence E. Fronk. In 1938 Dr. Fronk and Dr. Wynn founded the Fronk-Wynn Clinic, now the Fronk Clinic. Due to ill health he withdrew in 1950 from the clinic. In 1952 he entered into private practice in Houma, Louisiana, specializing in obstetrics.

Dr. Wynn died February 8, 1961, at the age of 69. He was a Fellow of the American College of Surgeons, member of the American Medical Association, the Honolulu County Medical Society, Hawaii Medical Association, Phi Delta Theta, Nu Sigma Nu, and of the Honolulu Art Society. He was a member of the Pacific and University Clubs, the Oahu Racing and Polo Association, and the Rotary and Outrigger Canoe Clubs.

CLARENCE E. FRONK, M.D.

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

January 30, 1962, at 6:00 P.M.
Oahu Country Club, Honolulu

PRESENT

Dr. J. A. Burden, presiding; Drs. Allison, Andrews, Bergin, Benson, Cushnie, Nishijima, Richert, Wade (for Dr. Goodhue), and West plus Drs. George Mills, Pete Okumoto, and I. L. Tilden, and Messrs. Hugh Lytle and Howard Pearce.

ELI LILLY PROPOSAL

A letter from Eli Lilly & Co. proposing that instead of taking a booth at this year's annual meeting, they make a monetary contribution towards the HMA's postgraduate education fund, was read. It was understood that this would be on the basis of $1.00 for each doctor registrant, or $250. It was felt that although we appreciate their offer of cash, the doctors attending the annual meeting would get more out of the meeting if the drug firms continue to put up booths, since they add a certain amount of interest and color.

ACTION:

It was moved, seconded, and passed that the Lilly proposition be turned down and that they be asked to continue with the booth.

HMA RELATIVE VALUE SCHEDULE

Dr. Mills presented the material contained in his letter which had been circulated. He said the medical profession was in a great state of confusion over fee schedules and invited the Council to discuss his proposal that a statewide relative value schedule be adopted and a committee formed to take over the responsibility of negotiating statewide contracts and fees. He pointed out the differences between CMA's 1957 and 1960 schedules, and said that the physicians had to decide whether they want a fee schedule or a relative value schedule. They can't have both. If they have a fee schedule, the specific fees are continually changing and they disregard totally the relative value study itself. Dr. Cushnie spoke on the importance of control of the committee.

ACTION:

It was moved, seconded, and passed that the Hawaii Medical Association adopt the 1960 California Relative Value Study and leave it up to the committee to recommend conversion factors.

Dr. Richert moved that the President be empowered to appoint the committee to function as coordinator with the relative value idea and a conversion factor. This was seconded by Dr. Allison but the motion was modified before it was put to a vote. Dr. Burden spoke of the new committee he is forming to act as a negotiating committee. He visualized that if this committee does a good job, as he had every reason to expect, it will be easier to convince the counties that it can represent the state in other areas. He thought one area the committee could function in is on the BCC schedule. It was agreed that once this committee is formed, it will have to come up with necessary mechanics.

ACTION:

It was moved, seconded, and passed with one dissenting vote that the President appoint a committee to work with the relative value schedule in relation to the component county societies.

CYTOLOGY REGISTRY

Dr. Tilden gave the background of the statewide Tumor Registry and outlined the make-up of the commission which governs it. The present proposal is to invite the cytology laboratories on a voluntary basis to send in duplicates of their reports to the Hawaii Tumor Registry. He outlined the funding for this project and its connection with the American Cancer Society.

ACTION:

It was moved, seconded, and passed that the Council of the Hawaii Medical Association approve of the establishment of a statewide cytology registry to be under the direction and control of the Hawaii Cancer Commission.

Dr. Burden said that in talking with the Department of Health, he learned that their only concern was the funding. They were apprehensive that after a few years the Cancer Society might drop the project and they would be asked to take over. Dr. Giles felt that the Registry should have set bylaws about who has access to the records. Dr. Tilden assured him that this would be looked into carefully before it is even started.

Dr. West spoke at length on the work that one doctor, Frank Spencer, had performed in connection with the cytology laboratory.

ACTION:

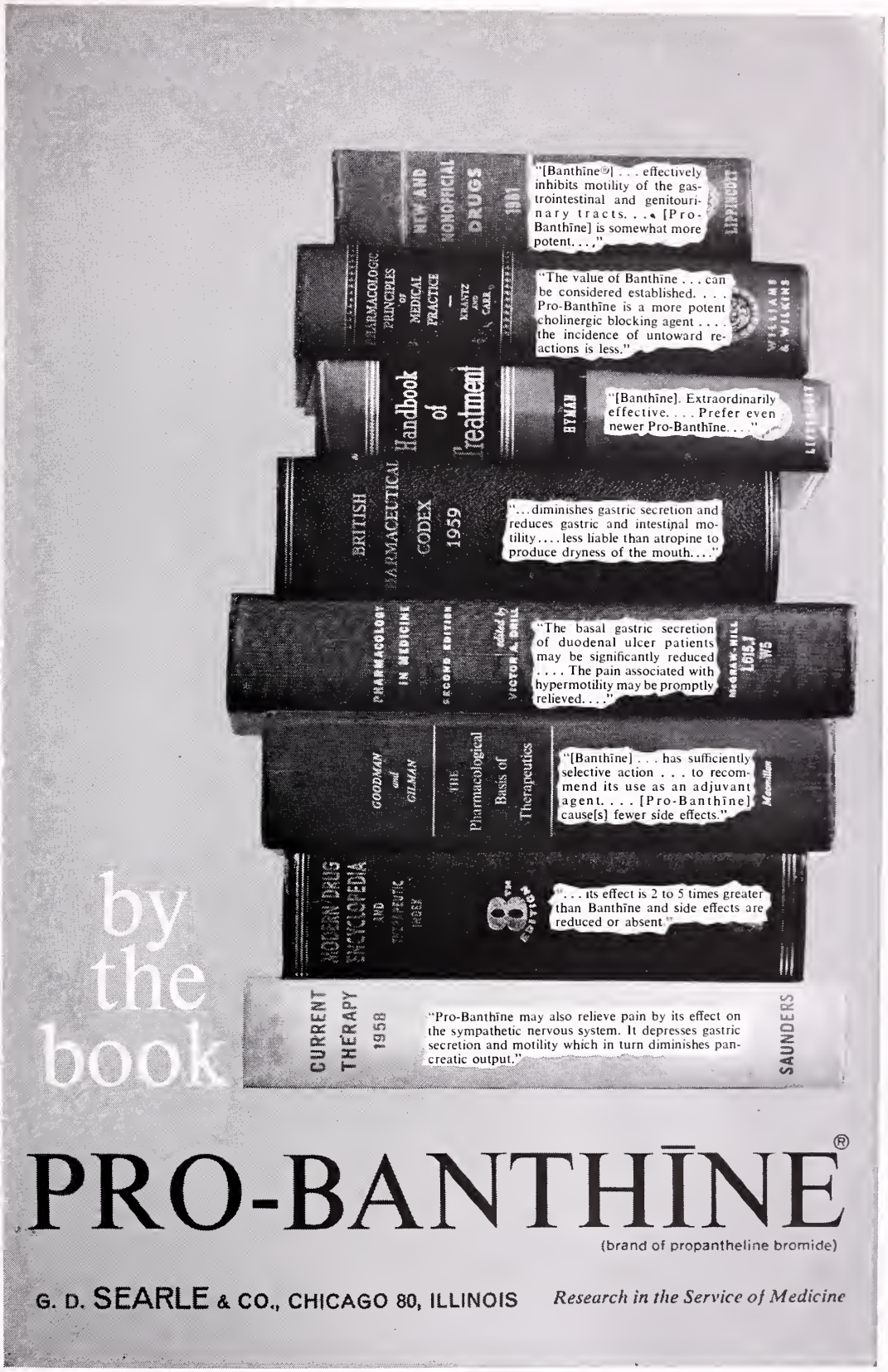
It was moved, seconded, and passed that the Hawaii Medical Association give a vote of thanks to Dr. Frank C. Spencer for the many years and hours of service he had rendered in cancer detection work for other doctors in this community through the cytology laboratory.

The letter Dr. Reppun addressed to Dr. Spencer with a copy to Dr. Burden was discussed. Dr. Tilden told the Council why the cytology work was stopped. When the Hawaii Cancer Society became affiliated with the American Cancer Society in order to continue the program, a separate agency had to be created under its own separate board of directors. A national society of pathologists protested against their members participating in a free program of this nature. At the same time the yield became less and less. When the project was first started, one in 300 smears was positive. In the last year this ratio was reduced to one in 1,000, which probably meant that Hawaii had screened out the latent *in situ* cancers in its female population. One-fifth of the local cancer society's budget was being spent for this project and they thought that since the women had become educated in this field, their money could better be spent in educational work in other areas. Free services will be given to the indigent and medical indigent. It was agreed that Dr. Burden should write Dr. Reppun and advise that the HMA had investigated the matter thoroughly and supports the move of the Oahu Cytology Laboratory.

SECRETARY'S REPORT

Dr. West advised that in October there were three additions to the roster from Honolulu County: Drs. Harold Y. Nekonishi, Francis M. Terada, and Benjamin C. K. Tom, and one deletion, Kenneth Rusch. In November, there was one addition from Honolulu, Dr. Casimer Jasinski. There was one request for waiver of dues, Dr. James Luce's county secretary requested waiver of Dr. Luce's 1962 dues due to Dr. Luce's present status as a volunteer worker with Medico.

continued page 362


by the book
"[Banthine®] . . . effectively inhibits motility of the gastrointestinal and genitourinary tracts. . . . [Pro-Banthine] is somewhat more potent. . . ."
NEW AND NONOFFICIAL DRUGS 1961
"The value of Banthine . . . can be considered established. . . . Pro-Banthine is a more potent cholinergic blocking agent . . . . the incidence of untoward reactions is less."
PHARMACOLOGIC PRINCIPLES OF MEDICAL PRACTICE
Handbook of Treatment
"[Banthine]. Extraordinarily effective. . . . Prefer even newer Pro-Banthine. . . ."
BRITISH PHARMACEUTICAL CODEX 1959
"... diminishes gastric secretion and reduces gastric and intestinal motility . . . . less liable than atropine to produce dryness of the mouth. . . ."
PHARMACOLOGY IN MEDICINE
"The basal gastric secretion of duodenal ulcer patients may be significantly reduced . . . . The pain associated with hypermotility may be promptly relieved. . . ."
GOODMAN and GILMAN
The Pharmacological Basis of Therapeutics
"[Banthine] . . . has sufficiently selective action . . . to recommend its use as an adjuvant agent. . . . [Pro-Banthine] cause[s] fewer side effects."
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"... its effect is 2 to 5 times greater than Banthine and side effects are reduced or absent."
CURRENT THERAPY 1958
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and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

**Warning—May be habit-forming. Subject to Federal Narcotic Regulations.*

No. 1 — gr. ⅛
No. 2 — gr. ¼
No. 3 — gr. ½
No. 4 — gr. 1



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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

BERYL UYEHARA, *Editor* MAX BOWMAN, *Associate Editor*

Ode to a Urinalysis Lab

What is yon fragrance in the air?
'Tis urine, urine everywhere.
Those little bottles in a row,
Their prec ous contents for to show.

Some are a lovely amber shade,
Others are more like lemonade.
Still each one yields that smell renowned,
Whether it's pale or golden brown.

Into the centrifuge to spin it.
Can you find the sugar in it?
Mix it, pour it, slosh it, slop it,
Stir it, shake it, spill it, mop it.

Inhale the smell as you pipette it.
How can anyone forget it?
Count the white cells and the red.
Good Lord, this patient must be dead!

Test it for sugar and for bile.
Don't fret, just hold your nose and smile.
For after all is said and done,
Isn't urinalysis fun?

AUTHOR UNKNOWN

Laboratory Findings Aiding in the Diagnosis of Untreated Pernicious Anemia

Pernicious anemia is a chronic anemia characterized by an abnormal formation of blood along with an increased blood destruction, achylia gastrica, and disturbances of the gastro-intestinal tract and nervous system. The condition's mechanism is questionable but is thought to arise from a lack of hematopoietic principle which is normally formed in the stomach by the action of the intrinsic factor present in normal gastric secretions on the extrinsic factor or vitamin B_{12}, absorbed from the intestine, and stored in the liver until used for cell development. In recent modifications the extrinsic factor and hematopoietic principle are thought to be the same thing, and the intrinsic factor permits its assimilation rather than transformation. In pernicious anemia there is a lack of the intrinsic factor, and the extrinsic factor passes through the body unabsorbed. Particular laboratory procedures are used to differentiate this condition from others that might interfere with hematopoietic principle absorption, storage, or utilization.

The main defect in P.A. is faulty blood construction from a lack of the extrinsic factor which slows down cell division and arrests the erythrocytic maturation in the megaloblastic stage. This is reflected in the bone marrow by the presence of a very large per cent of megaloblasts, and increased percentages of macrocytes, giant juvenile metamyelocytes, and multisegmented polymorphonuclear neutrophils. The hyperplasia of red cells is characteristic, with 30 to 50 per cent nucleated cells and the appearance of such immature forms as promegaloblasts, basophilic megaloblasts, and orthochromatic megaloblasts. It has been said that a sign of therapy success is the magaloblastic hyperplasia of bone marrow. An increase of normal myeloid leukocytes is accompanied by the development of very large cells especially in the metamyelocytic stage. An irregularity of nuclei and a slow cytoplasmic development may well be the start of large, multisegmented neutrophils. There may also be an increase of lymphocytes, and a decrease of abnormal megakaryocytes. A bone marrow examination gives valuable confirmatory information but upon therapy may quickly change toward normal.

Of great diagnostic valuc is a blood smear study. Macrocytosis is very characteristic and in general is directly related to the severity of the anemia. Characteristic of advanced anemia and blood destruction is marked poikilocytosis in which cells are often pear shaped or oval. Marked anisocytosis appears, with a greater than normal variation in cell diameters. All red cells are well filled with hemoglobin and appear supersaturated because of their greater thickness which allows less light to pass through them. Diffuse polychromatophilia, basophilic stipples, acidophilic Cabot's rings, Howell-Jolly bodies, and nucleated red cells, especially megaloblasts, reflect cell regeneration and indicate that the cells leavc the bone marrow before maturing. There is a greater decrease in the red cell count than in the quantity of hemoglobin or the volume of red cells since there is an increased corpuscular size and hemoglobin content, and less than a million cells per cubic millimeter is not impossible. The total blood volume is reduced, although the total plasma volume may bc increased, due to the decrease in red cells. Usual

characteristics are an increased mean corpuscular volume, mean corpuscular hemoglobin, and color index, with a normal mean corpuscular hemoglobin concentration.

Generally platelets are less than 100,000 per cubic millimeter in red counts under two million per cubic millimeter. Alterations of the megakaryocytes in the bone marrow result in this reduction and in irregularly shaped and sized platelets. A prolonged bleeding time, a poor clot retraction, and a nearly normal coagulation time are common.

Usually the reticulocyte count is normal and the cell resistance to a hypotonic saline solution is minimal. The red cell life span can be as low as sixty or even twenty days, implying a cell defect, but upon giving a normal person these cells the destruction rate is normal, implying a noxious influence from the vitamin B_{12} deficiency. A high icterus index, from 20 to 25 units, and an indirect Van den Bergh reaction, reflect blood destruction.

Generally the white blood count is decreased, with an absolute decrease in the polymorphonuclear neutrophilic leukocytes and a relative increase in lymphocytes. Many enlarged, multisegmented neutrophils with ten or more oddly shaped and sized lobes are found, along with a shift to the right. The chromatin seems less packed and the cytoplasmic granules larger and more acidophilic. From 0.5% to 1.5% immature forms of the myeloid series may be found. Neutrophilic changes usually precede pronounced red cell changes.

A characteristic absence of free hydrochloric acid even after a test meal or histamine stimulation is found. About 98% of the cases have complete achlorhydria, a reliable criterion for diagnosis. This gastric secretion deficiency precedes symptoms and persists even after treatment. It should not be thought that the intrinsic factor is hydrochloric acid.

Stool and urine usually reflect increased blood destruction. Stools are often soft and dark with excess urobilinogen. Urine usually has a fixed low specific gravity, a brown color, moderate albumin, a few hyaline and granular casts, and an increase of urobilinogen.

The type of anemia and the nature of the deficiency are determined from the vitamin B_{12} therapeutic test. Within several days there is a characteristic reticulocyte response and a relief of symptoms. The reticulocyte response is directly proportional to the severity of the anemia or the degree of the bone marrow involvement, and inversely related to the original red count. Two to five days after vitamin B_{12} administration, the reticulocytes increase toward a peak of 10-40% in 7-13 days and then gradually fall off as they undergo maturation and cause a rise of the red count toward normal. The increase of erythrocytic maturation factor rapidly releases reticulocytes into the circulating blood, since the nucleated red cells in the bone marrow now have the factor they need in order to mature.

To rule out various causes of macrocytic anemia other than pernicious anemia, the patient's gastric juices are tested for intrinsic factor activity by assay with radioactive vitamin B_{12}. Four methods are available, but the measurement of orally given $B_{12}Co^{60}$ excreted in the urine is the most practical and popular. A large injection of vitamin B_{12} is followed two hours later by an oral dose of $B_{12}Co^{60}$. The per cent excretion is calculated by the comparison of the radioactivity of a 24-hour urine sample, a pretest urine, water, and a standard solution of $B_{12}Co^{60}$. Normally no vitamin B_{12} is excreted in the urine, but if the serum B_{12} binding capacity is exceeded by a large dose, then more than half is excreted by the kidneys in 24 hours. In pernicious anemia only 0-2.3% is excreted in the urine since the intrinsic factor deficiency means that only a negligible amount of $B_{12}Co^{60}$ can be absorbed and then flushed into the urine. With very little absorption in the intestine, practically all the vitamin B_{12} is excreted in the stool. A typical pernicious anemia pattern is a low per cent of absorbed $B_{12}Co^{60}$ flushed into the urine in the control test, and a return to a normal 7-22% excretion in the urine upon the addition of intrinsic factor to the orally given $B_{12}Co^{60}$.

Since the treatment of pernicious anemia is lifelong, an accurate diagnosis is important. After the laboratory technicians have the results of the ordered tests, the findings along with the clinical symptoms and case history aid the physician in his diagnosis. ●

DOROTHY ANN DEVEREUX, S.T. (ASCP)
E.M.G.H., *Bangor, Maine*

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Wintrobe, Maxwell M.: Clinical Hematology, 4th ed. Philadelphia, Lea and Febiger, 1958.



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Convention time has come again,
Take pot luck, end in a mess;
Go in peace, arrangements made.
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Correspondence *continued*

dividual has not responded to our efforts. Some recent work was done by Dr. Horace Hodes of Mount Sinai Hospital in New York which seems to indicate that we may be on the verge of just such a procedure.

In summary, it seems clear to me that; the Salk vaccine is effective to a great degree in preventing and modifying the morbidity and mortality of paralytic polio; that the Sabin vaccine is at least as good if not better; that there is little likelihood of a killed virus maintaining immunity for prolonged periods without repeated booster doses throughout the susceptible (?) period of life; that there is good likelihood that the living virus vaccine would confer lifelong immunity following the initial successful vaccination.

JOHN R. STEPHENSON, M.D.

January 8

Notes and News *continued*

patient was found 50 feet up a banyan tree in the patio of the mental health ward.

Dr. Bill Stevens represented the HMA in presenting awards in medical reporting to Bob Krauss and Tomi Knaefler at the Gridiron Show.

Seems that **Dr. Ted Tomita** has conquered the most "unsurmountable and dreaded" shot in golf—he recently won at Waialae with a 77 gross.

Dr. Bob Johnston received unsolicited and definitely not sanctioned publicity when the HAL used a picture of him and his dog for advertising—it aroused the ire of the Medical Practice Committee!

Dr. J. Alfred Burden and Hugh Lytle of the HMA recently announced the inauguration of a new weekly radio program "Ask Your Doctor." Many local physicians have anonymously appeared and given their views at the regular Friday KGMB programs.

Dr. Sumner Price granted provisional certification to 33 of the State's 49 nursing and care homes and ordered them to clean up deficiencies in their standards.

Maui may test new mental treatment, read recent headlines—**Drs. R. S. Spencer,** Chief, State Division Mental Health, and **J. K. Wallis,** of Maui, outlined the so-called experimental project with possibilities of a half-million dollar Federal grant.

The closing down of the Oahu Cytology Lab caused a little furor. **Dr. Fred Reppun** was the most vociferous.

AAPS-sponsored essay contest involving high school students drew stories and protests when it was reported that "extreme right wing literature" was distributed to public schools throughout the state. Many in the profession got into the controversy. **Dr. F. J. Pinkerton's** (local representative of the AAPS) reply drew editorial fire.

Dr. Pete Okumoto made the news three times recently. He was elected President of the 442nd Veteran's Club and was pictured presenting a $500 check to the Hilo Campus (UH) Library in memory of the late **Dr. Toshio Kutsunai.** Later his reappointment to the Board of Regents was confirmed.

Dr. Katherine Edgar appeared and spoke at the recent public hearing on detention home medical lack.

continued page 360

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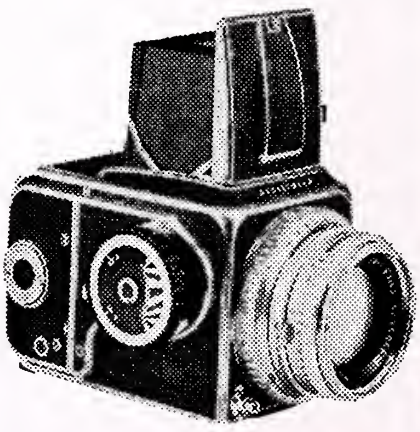
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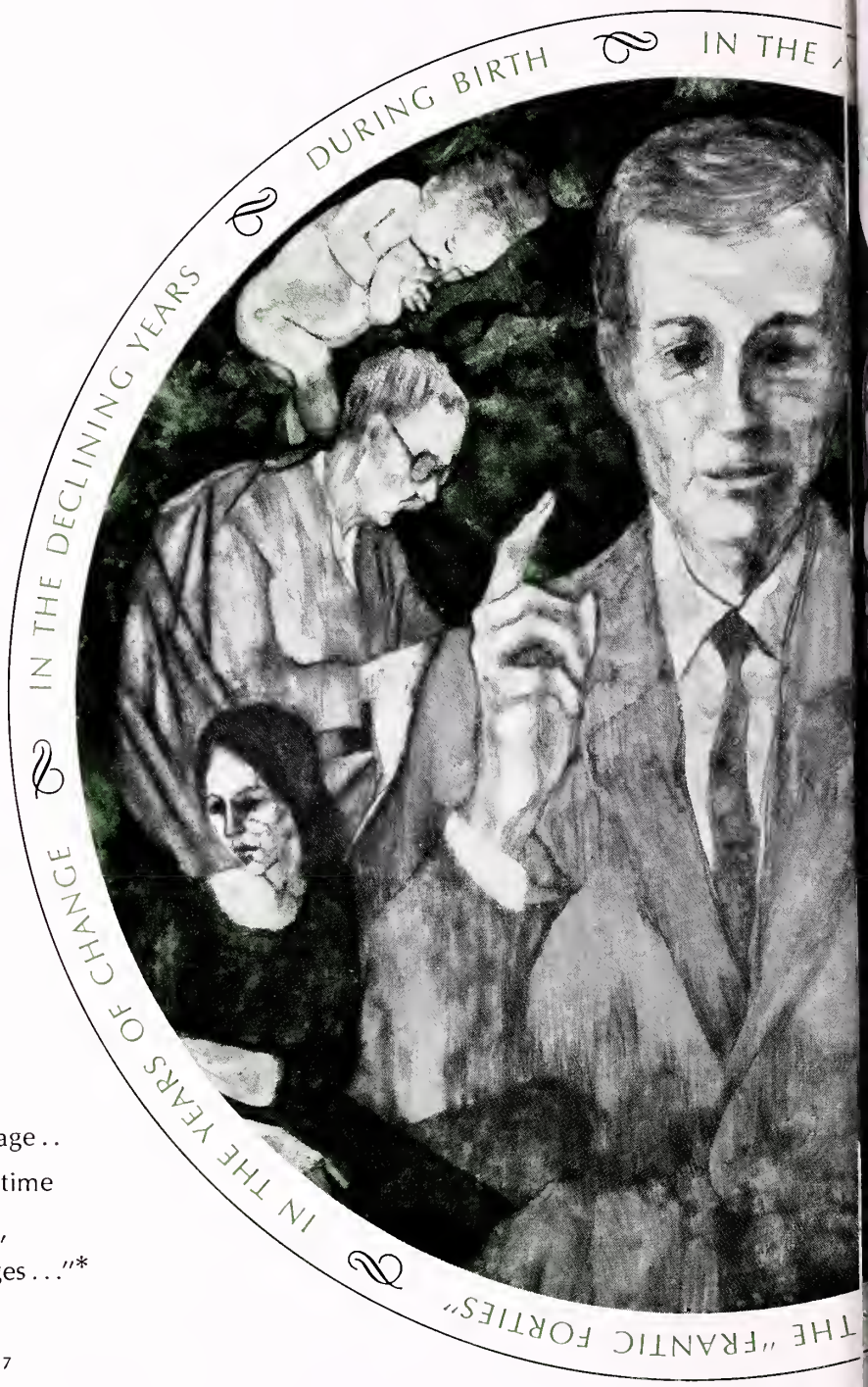
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And one man in his time
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in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

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Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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New Affiliations

Dr. L. G. Van Loon has resigned as Hana County physician and is now with the Department of Health at Kalaupapa, Molokai.

Dr. A. Leslie Vasconcellos has moved from Keeaumoku Street to Room 103, 1488 South King Street.

Dr. Don S. Poulson has moved to Room 207 of the Nuuanu Medical Center (1374 Nuuanu Avenue).

Dr. William D. Carter announces the opening of his office at 125 Hekili Street, Kailua.

Dr. S. J. Buist has transferred headquarters from the main Medical Group Building to Kailua.

Newest tenants at 1441 Kapiolani are **Dr. Lyle Bachman,** Suite 602, and **Dr. Carl H. Lum,** Suite 608.

Dr. R. C. Durant is back at 305 Royal Hawaiian Ave.

Hawaii Doctors in Print

Dr. Walter B. Quisenberry's article "Ethnic Differences and Socio-cultural Factors in Cancer in Hawaii" appeared in the 1961 fourth quarter issue of *Medical Arts & Sciences*. **Dr. Grant N. Stemmermann** had two articles published in December; one on "Esoinophilic Granuloma of the Appendix—A Study of its Relation to Strongyloides Infestation" in the *American Journal of Clinical Pathology*, and the other, "Extrapelvic Carcinoma Metastatic to the Uterus" in the *American Journal of Obstetrics & Gynecology*. **Dr. William A. Myers's** article on "A Pediatric Practice in Honolulu, Hawaii" appeared in the October issue of *Annals of Allergy*.

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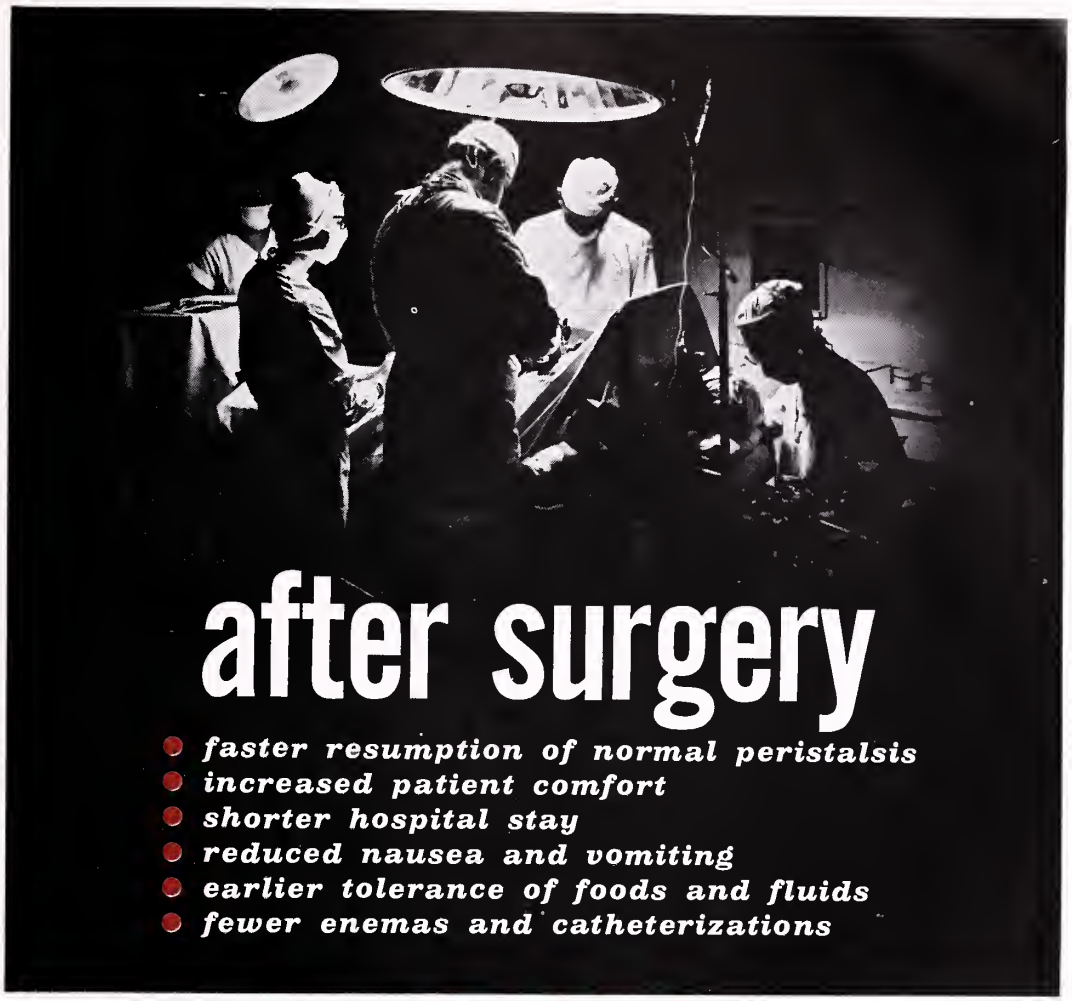
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Council Meeting Minutes *continued*

ACTION:

It was moved, seconded, and passed that the membership changes as presented in the Secretary's report be accepted.

TREASURER'S REPORT

Dr. Nishijima asked about the necessity of maintaining a general fund and was advised that it is axiomatic that a medical association maintain a reserve equal to one year's operating expenses and the Association has been working towards this goal for many years. It was noted that the President's contingency fund was increased rather than earmark a set sum for a mainland speaker.

ACTION:

It was moved, seconded, and passed that the Treasurer's Report, including the budget be approved.

The Treasurer advised that he had received a bill from the Public Relations Chairman which included several miscellaneous items for which he had attached bills. However, one item, $47.43 for lunches at the Pacific Club, had no bill attached.

ACTION:

It was moved, seconded, and passed that Dr. Stevens's full bill of $66.82 be paid.

PUBLIC RELATIONS FUND

Mr. Lytle gave a verbal report on activities in the public relations field. He said that perhaps it could more properly come from Dr. Giles. He mentioned recent advances including the new weekly 15-minute radio program. When this is well established it is hoped that a

continued page 366

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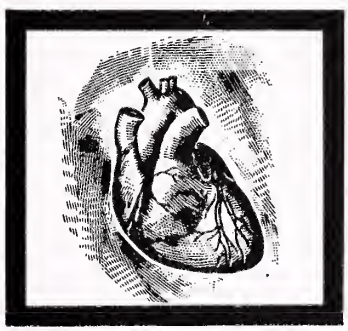
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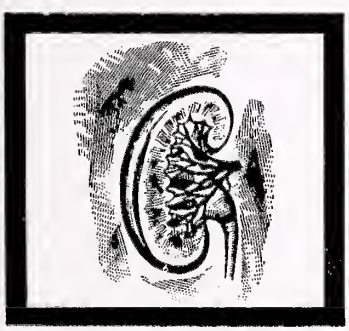
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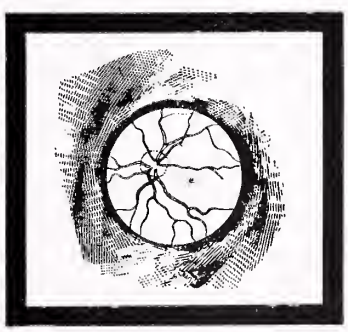
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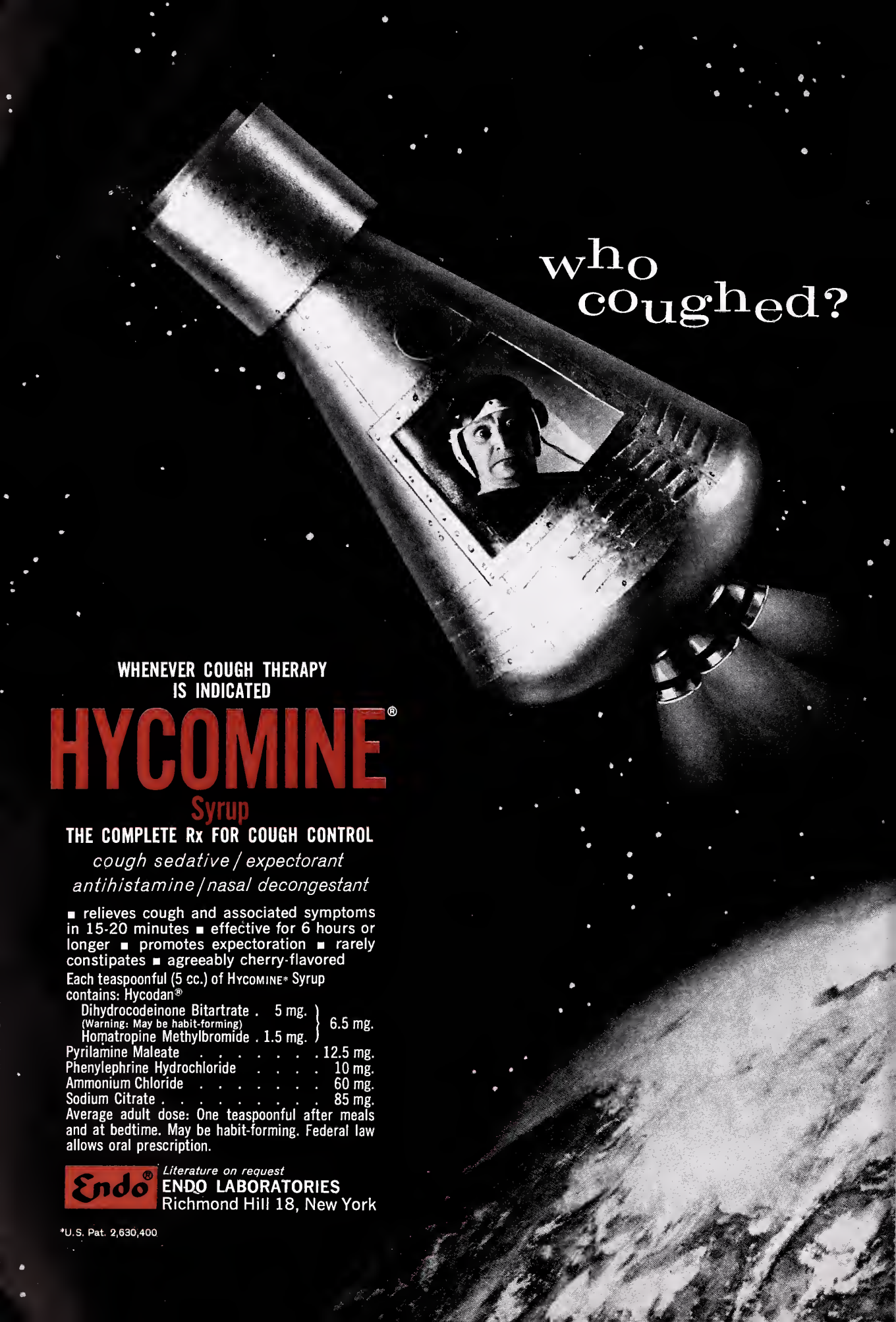
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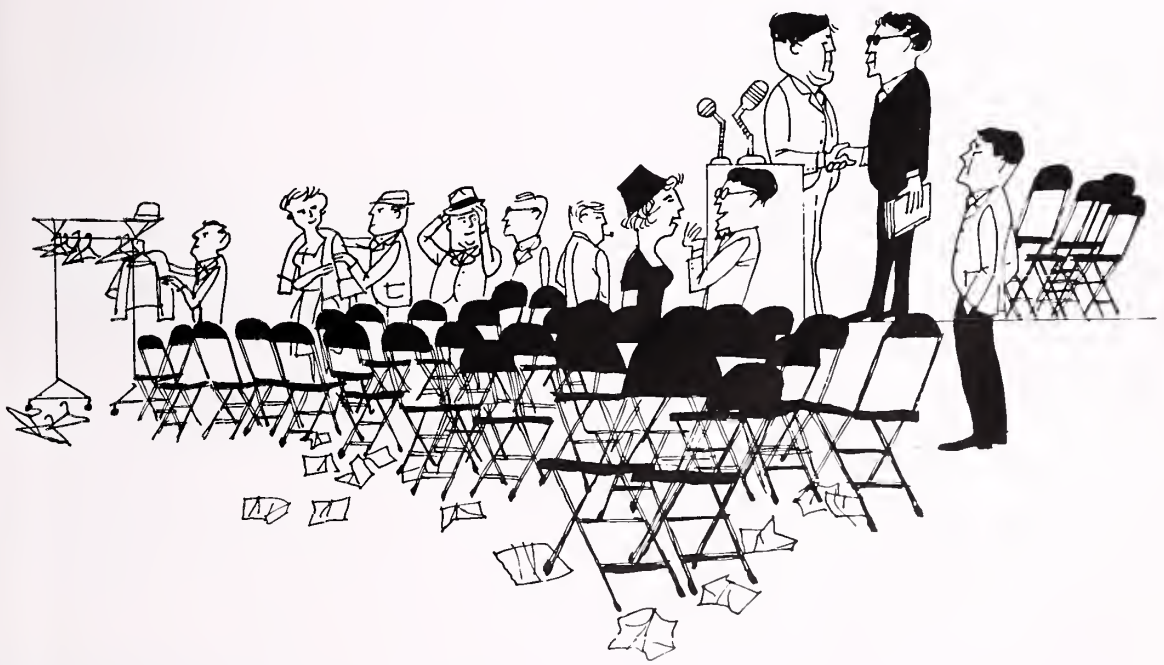
But now we wonder . . . because so many of you have said to us lately, either orally or in writing, "Why are you telling us this? Our patients are the ones who really need to hear this story."

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Council Meeting Minutes *continued*

sponsor can be obtained. The prizes awarded for outstanding medical reporting were well received and have resulted in increased interest among the press in straight medical and science reporting. He advised that the Association of Professions is getting off the ground and a second meeting is planned with the other professions in early March.

The Public Relations Committee has had 40 formal and informal meetings and has helped formulate about 100 newspaper releases, among them the ones relating to the HMSA contract. This could have resulted in unfortunate publicity but was treated favorably by the press. The Drugs for Dooley program is now Kokua for Samoa and will get off the ground very soon. The water sports program was discussed by both Dr. Richert and Dr. Giles. There has been difficulty in communicating with Mr. Bill Smith. Dr. Bergin spoke on the possibility of buying space in the newspapers. The cost of this type of public relations was outlined and he was advised that for the present, the committee had decided to channel this money into a radio program, which is much less expensive. He noted how well received the letters were on carbon tet and advised that KORL is continuing to give us free spot announcements. He advised that Mr. Edwin Honda had been employed to work with the Legislature.

Mr. Lytle reviewed the newspaper publicity on the AAPS Essay Contest. The officers knew in advance they could not win a verbal battle with the press. It can't be done because the editors always have the last word. He said he was an editor once and had used the same technique. But the doctors did get on record and the thinking portion of the population will largely admire their intestinal fortitude, but the thinking portion of the population is in the minority and it tends to favor the medical profession anyway. Mr. Lytle said he shared in the responsibility for that final letter and he had mixed feelings concerning it. It felt good to go on record but you never have the last word with an editor. Let us not do that again in just that way no matter how outraged our feelings might be. He advised that the ILWU propaganda had been supplied to the newspapers but had not been used to date. He thought the positive facets of the overall program far outweighed the aspects of this one incident.

Dr. Burden said he did not write the letter to Heloise on carbon tetrochloride, he merely signed one that was written for him because he thought it was a good letter. He refused to sign the one on the AAPS Essay Contest because he thought it was a disgrace to the medical profession. He had prepared a statement but the consensus was that a letter would be better and the statement would be run separately. He did not know why the statement was not run. He said he was not apologising for the letter. He realized you cannot win with the editor but you can get your position before the public. He said this particular piece had no bearing on the contest. Dr. Bergin asked who put in the questionable material and was advised that no one knew. It was denied in Chicago and certainly no one here put it in.

NATIONAL BLUE SHIELD COVERAGE FOR THE AGED

Dr. Burden advised that although the cost and benefits for this proposed plan would be uniform, the fees are within the jurisdiction of the state. This would probably be the first assignment for the new negotiating committee.

NEGOTIATING COMMITTEE

Dr. Burden advised that he had met with the four county presidents. He had already appointed the following members from Honolulu County: Drs. C. M. Lum, Grover Batten, William Ito, Richard Moore, and George

continued page 368

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Council Meeting Minutes *continued*

Mills. Dr. Pinkerton had appointed the HCMS representative, Dr. Robert Hunter. Dr. Burden named Dr. Hunter the chairman of the committee. Dr. Burden advised that he had asked each neighbor island president to appoint one member to the committee. He had tried to impress on the county societies the fact that active participation will entail expense. He felt that he had sold them on the importance of the work of this committee. He said that with the Council's permission he would like to also designate this committee as the proper one to take up the relative value study work. It was explained that the work of this committee is purely financial as opposed to the Chronic Illness and Aging Committee, which takes care of the medical aspects of aging. Dr. Burden advised that in Florida they have no problems insofar as the aged are concerned and a plan for that group is now selling there. Dr. Mills said one of the reasons why the HMSA never had a program was that when this first came up it was estimated that there would be between four and seven thousand subscribers and they wouldn't touch it unless the number of people that might be covered were between thirty and forty thousand.

VETERANS CONTRACT

Dr. Giles reported that the Veterans contract had been gone over with Dr. Westover of the VA and there was now general agreement on the fee schedule. There was no problem with the surgical schedule but the committee had to compromise on the other portions and was not successful in getting all the fees up to the going rate. The contract has now been forwarded to Washington for official approval. The intermediary set-up will be discontinued.

PLAQUE

It was noted that the proposed presidents' plaque could not use the State seal but could have the unofficial HMA seal on one side and a serpent and staff on the other. The cost would be $345. The individual plaques cost $24.50.

ACTION:

It was moved, seconded and passed to approve of the expenditure for the Presidents' Plaque.

MEDICAL SCHOOL FOR THE UNIVERSITY OF HAWAII

Dr. Bergin said several years ago Governor Quinn appointed a committee of about 40 members to look into education beyond high school. At that time he asked them to study the feasibility of establishing a medical and other professional schools. The committee felt that Hawaii could not afford them since it costs something like $35,000 a year per medical student. Dr. Willard Wilson also submitted statistical information which showed that it took a population of over two million to maintain a medical school. They decided to forget about a medical school and go into WICHE instead. Dr. Burden said that at a WICHE meeting it was stressed that one of the solutions to the problem of obtaining higher calibre medical students was the establishment of a two-year school. This is one way of increasing the supply of doctors when there is no medical school in the area. This adds to the source of material for the upper classes of the already established four-year medical schools.

Dr. Richert said he had been serving for the last four years as a commissioner for WICHE. During the first year they met about three times in San Francisco with the deans of medical schools in the thirteen western states. These meetings gave greater insight into some of the problems. Within this commission there is a definite

continued page 370



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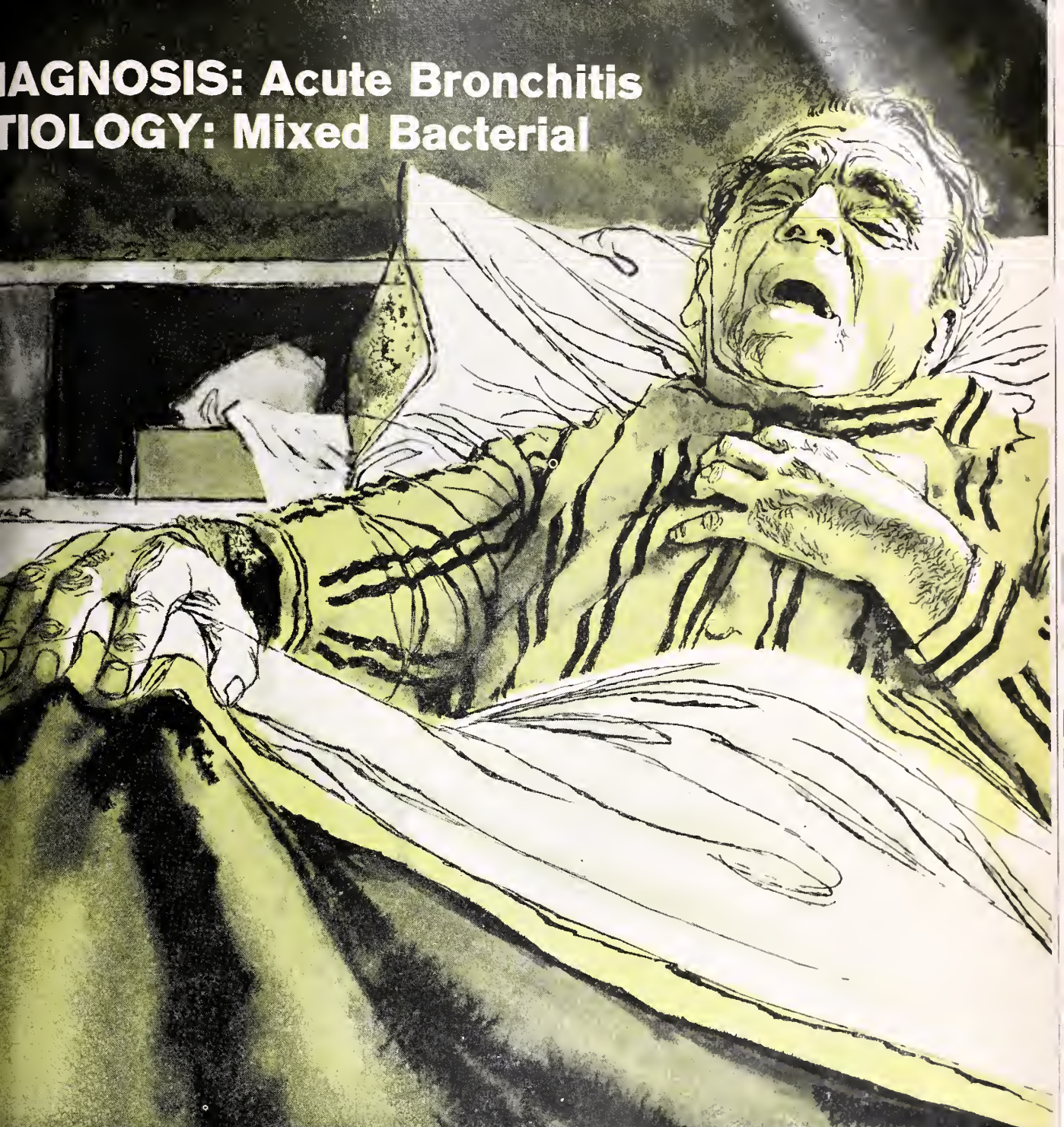
"Bookkeeping Control" is a commercial term that is sometimes used too loosely. It refers to the exercise of accounting techniques that will always reveal errors. The subject is elaborate, and of necessity must be simplified herein. In a nutshell, its meaning to the Doctor refers to a "System" of bookkeeping procedures that causes a smooth flow of figures and information into his records, and that immediately reveals any discrepancies in those records.

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Frieda M. Beezley, R.N., *Director*
— *or* —
Carole J. Manning, *Secretary*

90 N. King St., Room 210 **503-028**

Council Meeting Minutes *continued*

division of opinion between the educators and the deans of medical schools as to the value of two-year schools. The educators think it is a simple matter to start a two-year medical school while the deans say they are wrong and you have to have a definite tie-in with some medical school and a four-year school in which to place the men after they have completed their studies at a two-year school. As far as the deans are concerned there is only one two-year medical school over a long period of time that has really functioned efficiently—Dartmouth. The problem now is not just getting funds to set up a two-year school. The two-year schools cannot get basic science teachers to do the work. The other thing is that the medical schools now are switching more to the British style of teaching where they are putting the men more into clinical work earlier, which is impossible in a two-year school. The cost studies have been fairly consistent. The four-year school cannot be established for less than forty million dollars in capital outlay. A two-year school would run considerably less than that. The booklet "Medical Manpower Needs of the West" was very verbose but since then summaries have come out, which are well worth reading. Dr. Richert said that it was his personal opinion that this is a political move and is being done a little tongue in cheek. He didn't believe that any of the legislators when faced with the cold cash figures would go for the idea unless they could set 100 per cent financing from the Federal Government and he didn't think any of the doctors would favor this.

Dr. Giles thought it was premature to recommend a medical school. He didn't think there was anything against making a study and we should be in favor of a study. Dr. Richert said that funds and personnel for

continued page 373

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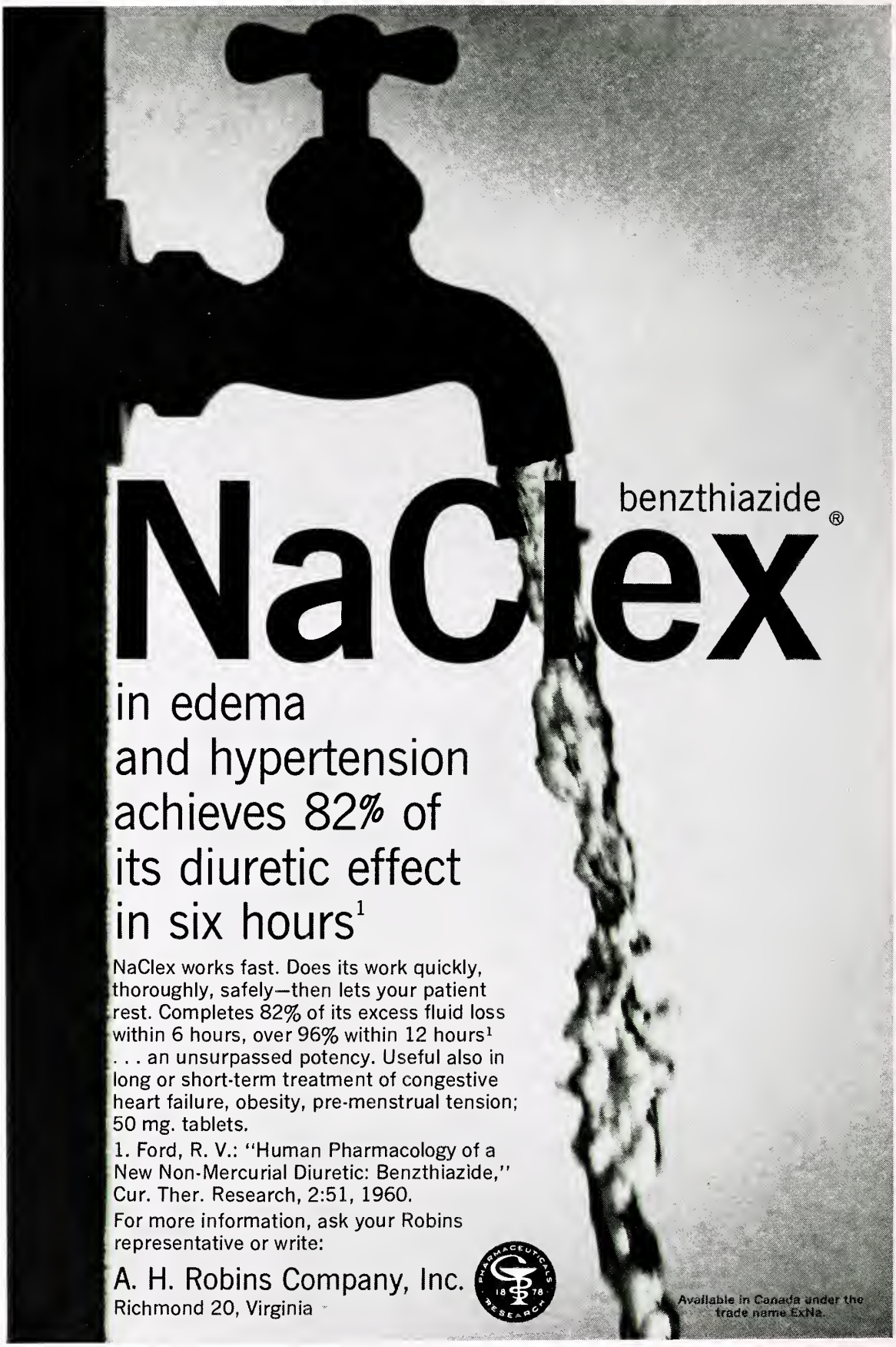
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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making a study are available through different national foundations.

ACTION:

It was moved, seconded, and passed, that the Hawaii Medical Association go on record as favoring a study as to the feasibility of establishing a two-year medical school here in Hawaii.

ANNUAL MEETING PUBLICITY

Mr. Lytle announced that the public relations services are available to all counties. He said he was a little worried about the publicity for the annual meeting. He was disappointed that the newspapers used so little of the material that was given them last year and asked if there were any objection to the idea that he go to one of the papers to see if a section could be worked up about the time of the meeting which would be financed by advertisers. The section would be filled with medical news. He was told that this would not present any problem and there were no adverse opinions from any of the Council members.

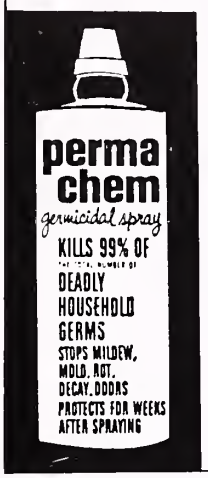
Dr. Burden thanked the councillors for their cooperation during the past year and the meeting adjourned at 10:30 P.M.

RODNEY T. WEST, M.D., *Secretary*

Election of officers and councillors will be held May 3. 1962.

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*Journal of AMA, April 4, 1959 Vol. 169 pp 1549-1556

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Book Reviews continued

and revision or modification of old concepts, thus preserving the dynamic presentations of the past editions.

Written for the medical student, technologists, as well as the specialist in this field, the material at times may seem redundant and even lacking in pedagogic discrimination. However, the thorough coverage, excellent colored reproductions, and judiciously selected bibliography make this volume an indispensable reference in this field for all those interested in hematology.

T. F. FUJIWARA, M.D.

Williams Obstetrics, 12th Ed.

By Nicholson J. Eastman, and Louis M. Hellman, 1230 pp., $16.00, Appleton-Century-Crofts, Inc., 1961.

THE AUTHORS have achieved and presented an up-to-date, comprehensive look at the advances in obstetrics since the publication of the 11th edition five years ago. To mention a few of the outstanding examples, I refer to the sections on abnormalities of pregnancy, the abnormalities of labor, and the abnormalities of the newborn.

The organization of the text remains in the same order. The increase in size of type and small changes in the illustrations add very little. Statistical materials are quoted the same as of ten years ago. It seems reasonable that these should have been revised.

S. J. BUIST, M.D.

★Clinical Obstetrics

By Benjamin Tenney, M.D., and Brian Little, M.D., F.R.C.S., 440 pp., $8.50, W. B. Saunders Company, 1961.

THE APPROACH to management of obstetrical patients, normal and abnormal, is very clearly and simply expressed as based on the experiences in the Department of Obstetrics and Gynecology at the Boston City Hospital. There is recognition of changing emphasis and newer approaches to problem cases. One good method of handling is advocated, with the acknowledgment of equally good results by other approaches.

One consistently irritating error was noted; a primigravida is frequently designated as a primipara.

This outstanding practical text is worthy of a place on any clinician's shelf.

S. J. BUIST, M.D.

★Thoracic Diseases Emphasizing Cardiopulmonary Relationships

By Eli H. Rubin, M.D., F.A.C.P., and Morris Rubin, M.D., F.A.C.S., F.C.C.P., in association with George C. Leiner and Doris J. W. Escher, 968 pp., $25.00, W. B. Saunders Company, 1961.

THIS BOOK attempts to orient the reader in current developments in thoracic diseases, with emphasis on cardiopulmonary relationship. One section is devoted to features in which the cardio-circulatory system is primarily involved, and another in which the respiratory system plays the dominant role. Chapters of timely interest include cardiac catheterization, angiocardiography, normal pulmonary physiology, and pulmonary function tests.

Cardio-respiratory conditions at birth, in the newborn and in infancy will be of particular interest to the obstetrician and pediatrician.

Sections which should interest internists and surgeons are those devoted to bronchial obstructive diseases, intrathoracic neoplasms and thoracic manifestation of systemic diseases. The problem of lung cancer is extensively discussed in several chapters.

The section on tuberculosis, emphasizing the changing pattern in this disease, is a "must" for physicians interested in diagnosis and treatment of this still ubiquitous illness. Atypical acid-fast organisms, drug-resistant tubercle bacilli, and the need for antetherapeutic antibiotic testing are well documented.

Sections on the various pneumonias, diseases of the

continued page 376

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pleurae, and thoracic injuries and emergencies complete a well-organized, excellently illustrated, up-to-date textbook. For the physician, generalist, or specialist, who treats patients with thoracic complaints, this book should be a welcome addition to his working library.

HOMER M. IZUMI, M.D.

★Surgical Gastroenterology

By Warner F. Bowers, A.B., B.Sc., M.D., M.Sc., Ph.D., 498 pp., $18.50, Charles C. Thomas, 1960.

DR. BOWERS has written an excellent book for the busy surgeon on the gastrointestinal tract. This book not only discusses physiology, but also indications, procedures, and complications expected, as well as what to do for them.

The most significant aspect of this book is discussion of surgical judgment that brings out the maturity in a surgeon. This book is recommended for all those interested in surgery.

WALLACE W. S. LOUI, M.D.

Also Received

Progesterone and the Defence Mechanism of Pregnancy

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A., 108 pp., $2.50, Little, Brown and Co., 1961.

PROGESTERONE is still mysterious, but these articles and verbatim discussions are highly instructive. For obstetricians and endocrinologists.

The Chemotherapy of Tropical Disease

By Sir Philip Manson-Bahr, M.D., and John H. Walters, M.D., 164 pp., $7.00, Charles C. Thomas, 1961.

NEW AND authoritative, but we don't have many of these in Hawaii.

The Putnam Medical Dictionary

By Norman Burke Taylor, M.D., and Allen Ellsworth Taylor, M.A., 933 pp., $4.95, G. P. Putnam's Sons, 1961.

SUITABLE for students, especially of nursing. Curious omissions—"sulfone," for example.

★Progress in Neurology and Psychiatry, An Annual Review

Vol. XVI, Edited by E. A. Spiegel, M.D., 617 pp., $12.75, Grune & Stratton, Inc., 1961.

AN INDISPENSABLE volume for neurologists and neuro-surgeons. There are nearly 2,000 index entries.

★The Human Adrenal Gland

By Louis J. Soffer, M.D., F.A.C.P., Ralph I. Dorfman, Ph.D., and J. Lester Gabrilove, M.D., F.A.C.P., 591 pp., $18.50, Lea & Febiger, 1961.

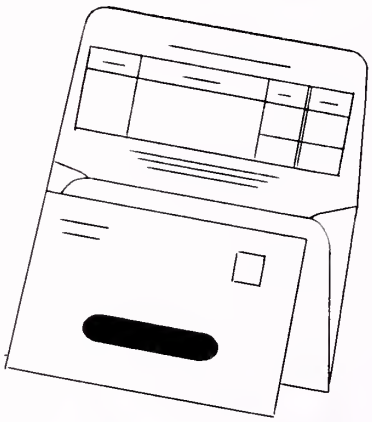
AN ENDOCRINOLOGIST, a biochemist, and an internist have combined to produce an excellent reference text.

Direct Analysis and Schizophrenia—Clinical Observations and Evaluations

By O. Spurgeon English, M.D., Warren W. Hampe, Jr., M.D., Catherine L. Bacon, M.D., and Calvin F. Settlage, M.D., 128 pp., $4.25, Grune & Stratton, 1961.

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106th Annual Meeting

PROGRAM

The House of Delegates and all breakfast and evening scientific sessions will be held at Puunene Meeting Hall.

THURSDAY MAY 3	7:00 A.M.	Breakfast ($2.00)
		Film: *Medical Genetics, Part I*
	7:30 A.M.	Panel on *The Treatment of Congenital Cardiac Anomalies*
		MODERATOR: Dr. Unoji Goto
		PANELISTS: Drs. Scott Brainard, Paul Gebauer, John F. Hanley, and Carl Mason
	8:30 A.M.	Intermission to view exhibits
	9:00 A.M.	Panel on *Inborn Errors in Physiology*
		MODERATOR: Dr. Norman Kretchmer
		PANELISTS: Drs. William F. Moore, Douglas H. Murray, John R. Stephenson
		• • •
	1:00 P.M.	House of Delegates Meeting
		• • •
	6:00 P.M.	No Host Dinner—Maui Palms Hotel
		• • •
	7:30 P.M.	*The Biochemical Aspects of Genetic Disease* by Dr. Norman Kretchmer
	8:30 P.M.	Intermission to view exhibits
	9:00 P.M.	*Congenital Anomalies of the Intestinal Tract* by Dr. Victor Richards
FRIDAY MAY 4	7:00 A.M.	Breakfast ($2.00)
		Film: *Medical Genetics, Part II*
	7:30 A.M.	Panel on *Gastrointestinal and Biliary Anomalies*
		MODERATOR: Dr. Victor Richards
		PANELISTS: Drs. James Cherry, A. O. Haff, Wallace W. S. Loui, William F. Moore
	8:30 A.M.	Intermission to view exhibits
	9:00 A.M.	Panel on *Prenatal and Obstetrical Factors Influencing Congenital Anomalies*
		MODERATOR: Dr. C. A. Wyatt
		PANELISTS: Drs. Marion Hanlon, C. C. McCorriston, Robert G. Rigler
	10:30 A.M.	Public Relations Committee Annual Meeting
		• • •
	1:00 P.M.	House of Delegates Meeting
		• • •
	5:00 P.M.	Cocktails as guests of the Maui County Medical Society at the Maui Country Club
	6:00 P.M.	No Host Dinner at the Maui Country Club ($3.50)
		• • •
	7:30 P.M.	*Presidential Address* by Dr. J. Alfred Burden
	7:45 P.M.	Introduction of new officers
	7:50 P.M.	Presentation of Robins Award
	7:55 P.M.	*The Biology of Tissue Transplantation* by Dr. Victor Richards
	8:40 P.M.	Intermission to view exhibits
	9:10 P.M.	*Biochemical Aspects of Development* by Dr. Norman Kretchmer
SATURDAY MAY 5	7:00 A.M.	Breakfast ($2.00)
		Film: *The Diagnosis of Hidden Congenital Anomalies*
	7:30 A.M.	Panel on *Congenital Neuromuscular, Skeletal, and Endocrine Diseases*
		MODERATOR: Dr. Norman Kretchmer
		PANELISTS: Drs. Thomas S. Bennett, Donald C. Marshall, Michael Okihiro, Donald E. Poulson, B. A. Richardson
	8:30 A.M.	Intermission to view exhibits
	9:00 A.M.	Panel on *Urinary Tract Anomalies*
		MODERATOR: Dr. Andrew Morgan
		PANELISTS: Drs. Herbert Y. H. Chinn, Robert K. Mookini, Walter S. Strode
		• • •
	6:00 P.M.	Cocktails and Dinner Dance ($7.50)
		Wailuku Hotel—Dinner Jackets optional
SUNDAY MAY 6	6:30 A.M.	Breakfast at the Maui Country Club (included in Golfers Tournament Fee)
	7:00 A.M.	Annual Golf Tournament, Maui Country Club ($7.50)
	1:00 P.M.	Picnic for Physicians and Wives at Maui Country Club ($3.50)

REGISTRATION

Registration at the Puunene Meeting Hall

THURSDAY, MAY 3—6:45-10:30 A.M. and 7:00-8:30 P.M.

FRIDAY, MAY 5—6:45-10:30 A.M. and 7:00-8:30 P.M.

SATURDAY, MAY 5—7:00-10:00 A.M.

Registration Fee—$15.00

WOMAN'S AUXILIARY ACTIVITIES

THURSDAY
MAY 3

10:00 a.m. Sightseeing and lunch at Lahaina

FRIDAY
MAY 4

9:00 a.m. Caffee at the home of Mrs. Clifford Moran, Keawakapu.

11:00 a.m. House af Delegates meeting at the hame af Mrs. J. A. Burden, Keawakapu.

7:30 p.m. Entertainment at Maui Country Club.

SATURDAY
MAY 5

9:00 a.m. Golf Tournament, Maui Country Club

ACKNOWLEDGMENT

Dr. Norman Kretchmer's participation on this program has been made possible by a grant from the National Foundation.

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	Page
Abbott Laboratories..Inserts (between pages 322 and 323, and pages 370 and 371)	
American Factors, Ltd.	312
American Tobacco Co.	323
Ames Company, Inc.	304, 379
Ayerst Laboratories	305, 380
Baxter, Don, Inc.	375
Burroughs Wellcome Co.	315, 320, 352, 353, 371
Carnation Co.	319
Ciba Pharmaceuticals	363
Coca-Cola Bottling Co. of Honolulu	362
Endo Laboratories	364
Ethicon, Inc.	310, 311
General Electric Co., Inc.	357
Hawaii Camera Company	356
Hawaii Medical Service Association	344
Hawaiian Airlines	301
Honolulu Paper Co.	318
Hood's Creative Corsetry	360
International Travel	356
Lederle Laboratories	369
Lilly, Eli, & Co.	297, 326
Lorillard, P., Co.	309
McKesson & Robbins, Inc.	362
Medical Industries	366
Medical Placement Bureau	370
O'Leary, Lydia, of Hawaii	374
Optical Dispensers	378
Pacific West Distributors, Ltd.	373
Pali Medical Building	374
Parke, Davis & Co.	298, 299
Pfizer Laboratories..Insert (between pages 316 and 317), 358, 359, 360	
Pharmaceutical Manufacturers Association	365
Professional Services, Inc.	368
Robins, A. H., Co., Inc.	Insert (between pages 312 and 313), 308, 313, 367, 372
Ross Laboratories	322
Saunders, W. B., Co.	317
Schering Corp.	325
Schuman Carriage Co., Ltd.	373
Searle, G. D., & Co.	351
Smith, Kline & French	316
Squibb, W. R., & Sons	306, 307
Star-Bulletin Printing Co., Inc.	376
Summers, Clinton D.	378
Tailby Nason Co.	377
Tassette, Inc.	324
Warren-Teed Products	361
Universal Motors	314
Von Hamm-Young Co., Ltd.	370
Warren-Teed Products	361
Williams Mortuary	366
Winthrop Laboratories	303

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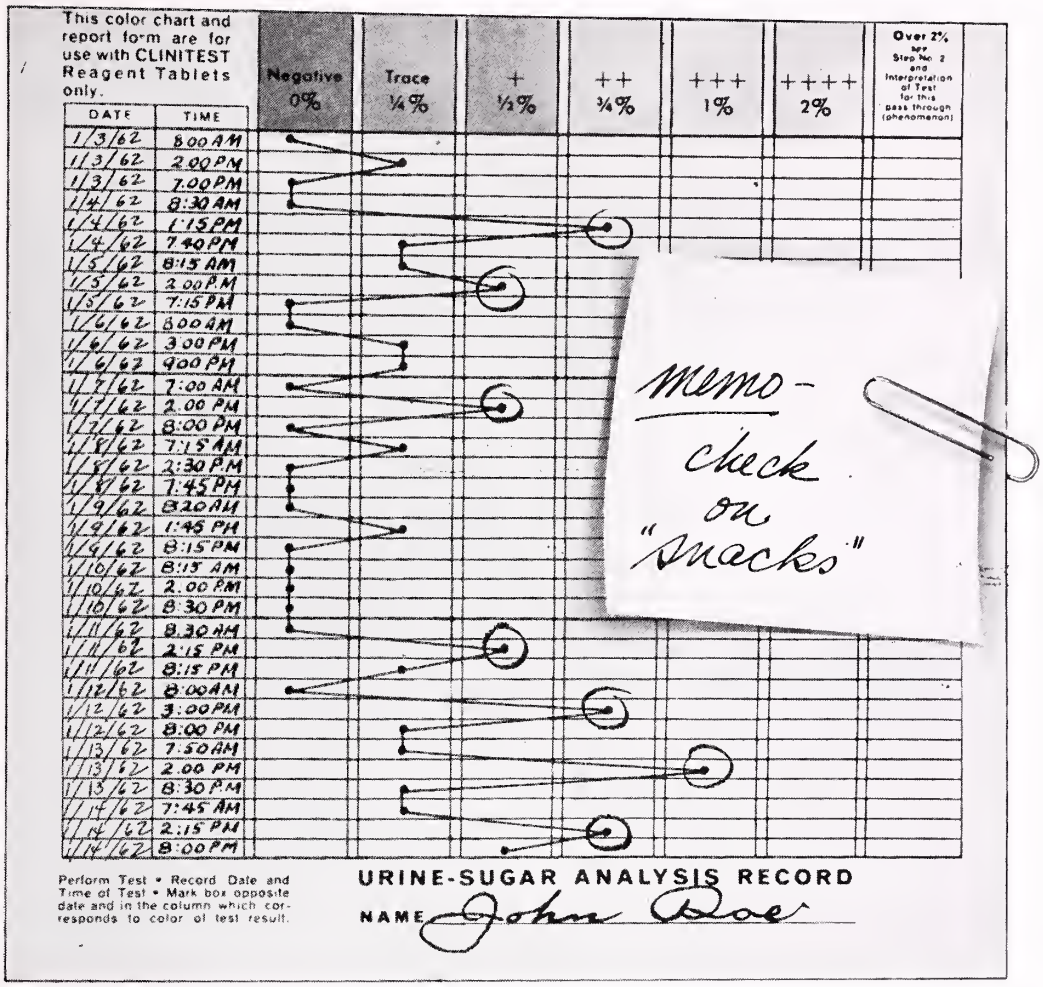
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2. Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. 73:43 (Jan.) 1961.

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In this issue

"Swimming pool" granuloma in Hawaii

Phenylpyruvic oligophrenia
(case report)

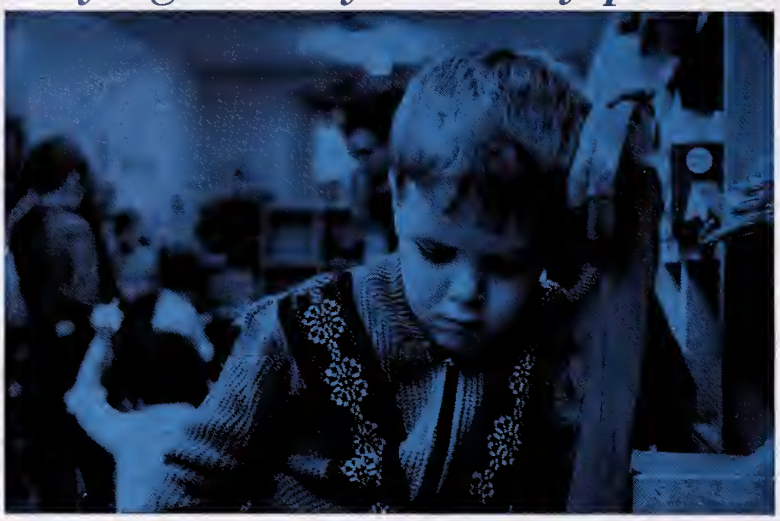
Hyperaldosteronism
(case report)

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Table of contents, page 386

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REFERENCES: (1) Roseman, E.: Neurology **11**:*912, 1961. (2) Bray, P. F.: Pediatrics* **23**:*151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: M. Clin. North America* **42**:*317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.: Postgrad. Med.* **20**:*584, 1956. (7) Merritt, H. H.: Brit. M. J.* **1**:*666, 1958. (8) Carter, C. H.: Arch. Neurol. & Psychiat.* **79**:*136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

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HAWAII MEDICAL JOURNAL

Contents

Volume 21, Number 5, May-June, 1962

Articles

Some Characteristics of "Swimming Pool" Disease in Hawaii 403
H. H. Walker, M.D., M. F. Shinn, M.T., M. Higaki, B.S., and J. Ogata, B.S.

Primary Hyperaldosteronism Due to Left Adrenal Adenoma, Report of a Case 410
Fred I. Gilbert, Jr., M.D.

Phenylpyruvic Oligophrenia 413
Frank L. Tabrah, M.D.

Gas Formation in Fetal Circulation as Evidence of Fetal Death 417
George Bracher, M.D.

Infant Research 419
David H. Crowell, Ph.D.

Editorials

Balnei Granuloma in Hawaii 422

Birth Defects 423

Features

Book Reviews 431
County Society News 428
In Memoriam—Doctors of Hawaii—XXXVIII 424
New Members 429
Notes and News 430
Poison Report 427
Presidents' Page 421
Reports and Snorts 398
This Is What Was New! 425

Hawaii Technologists' Bulletin

Problems Relative to the Reproduction of Microchemical Methods 438

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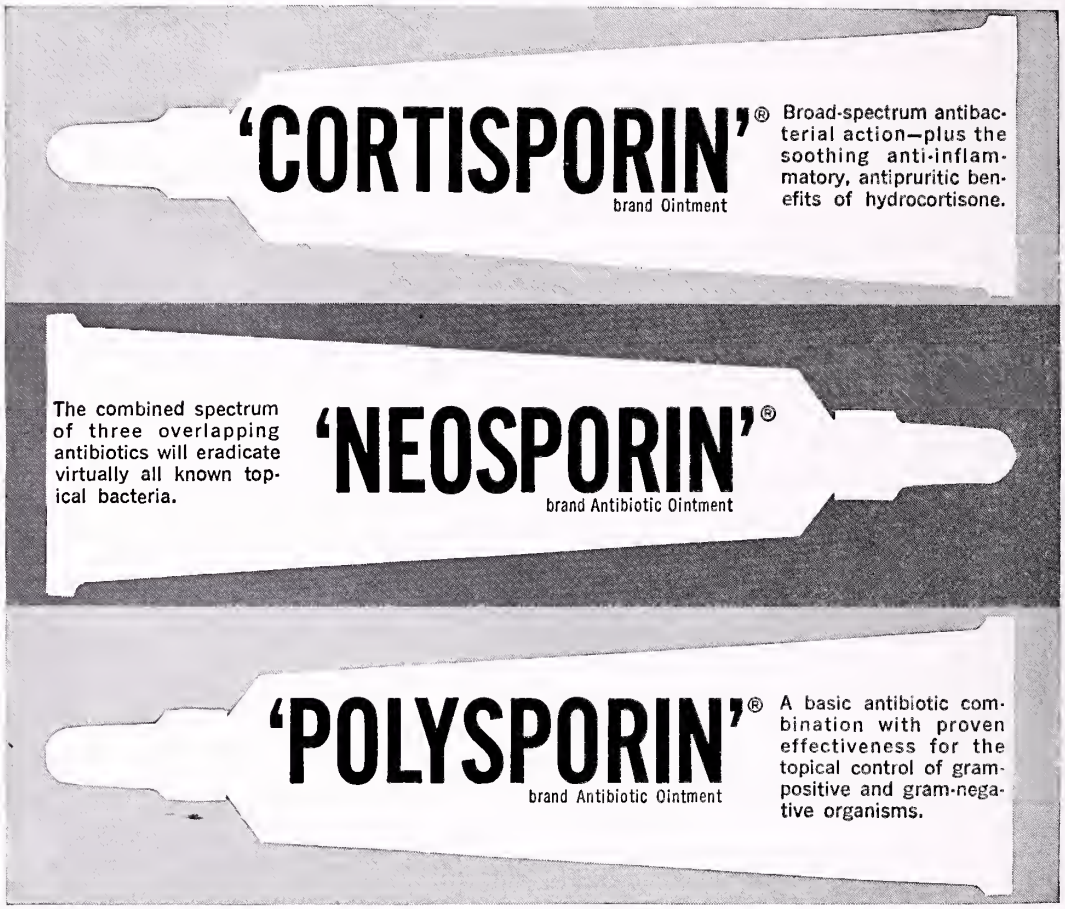
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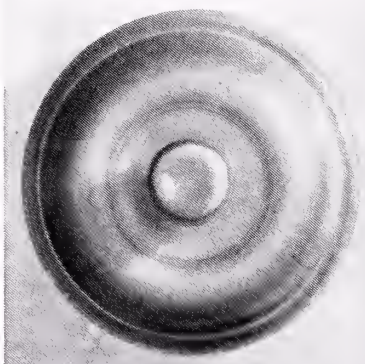
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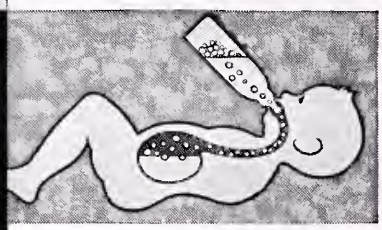


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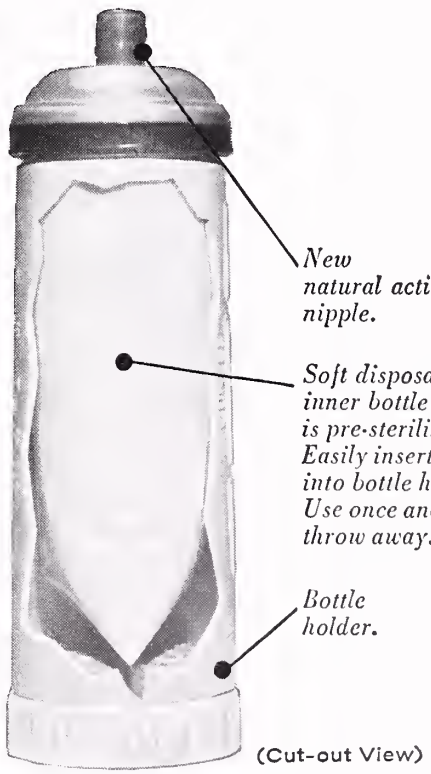
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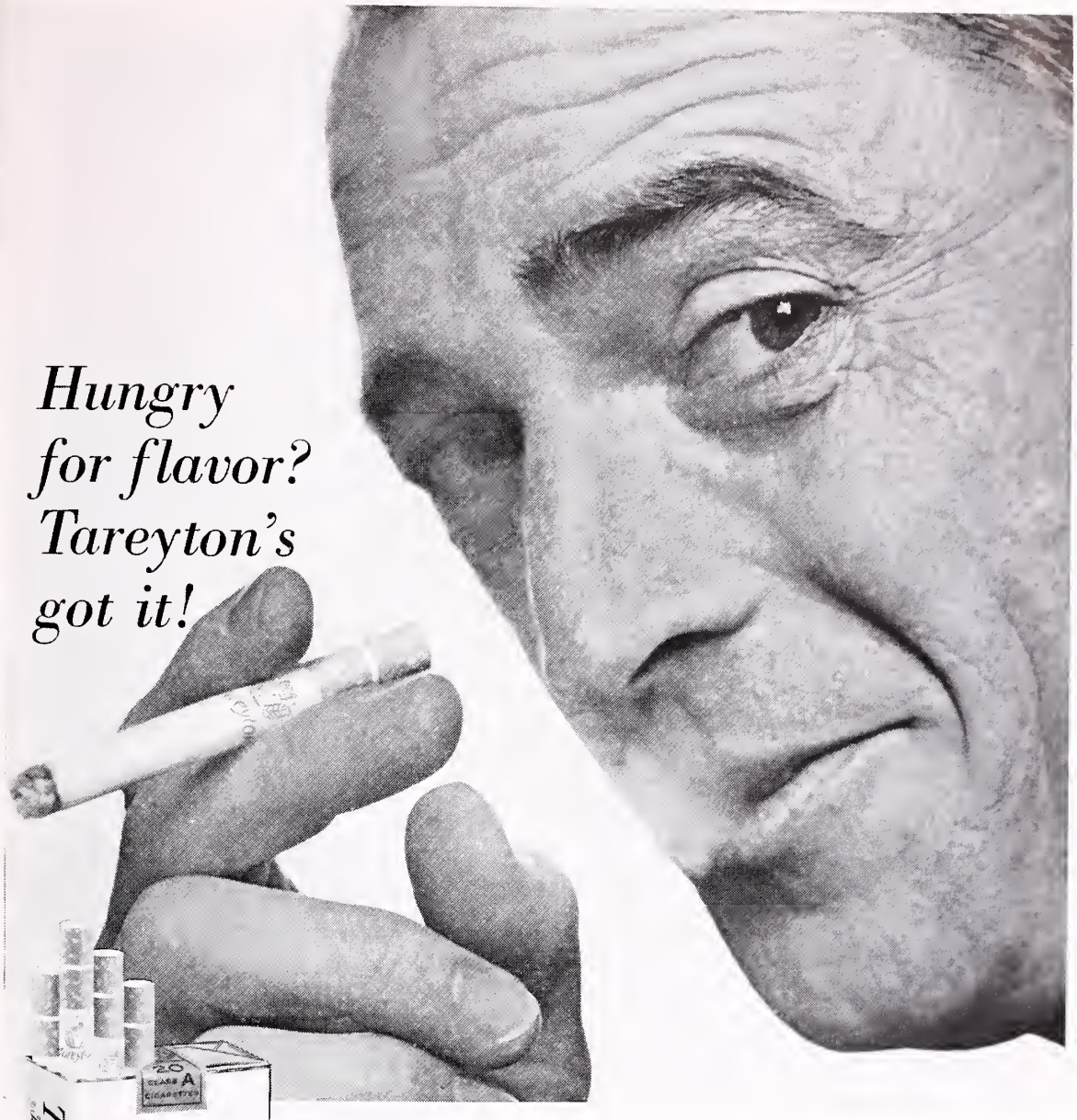
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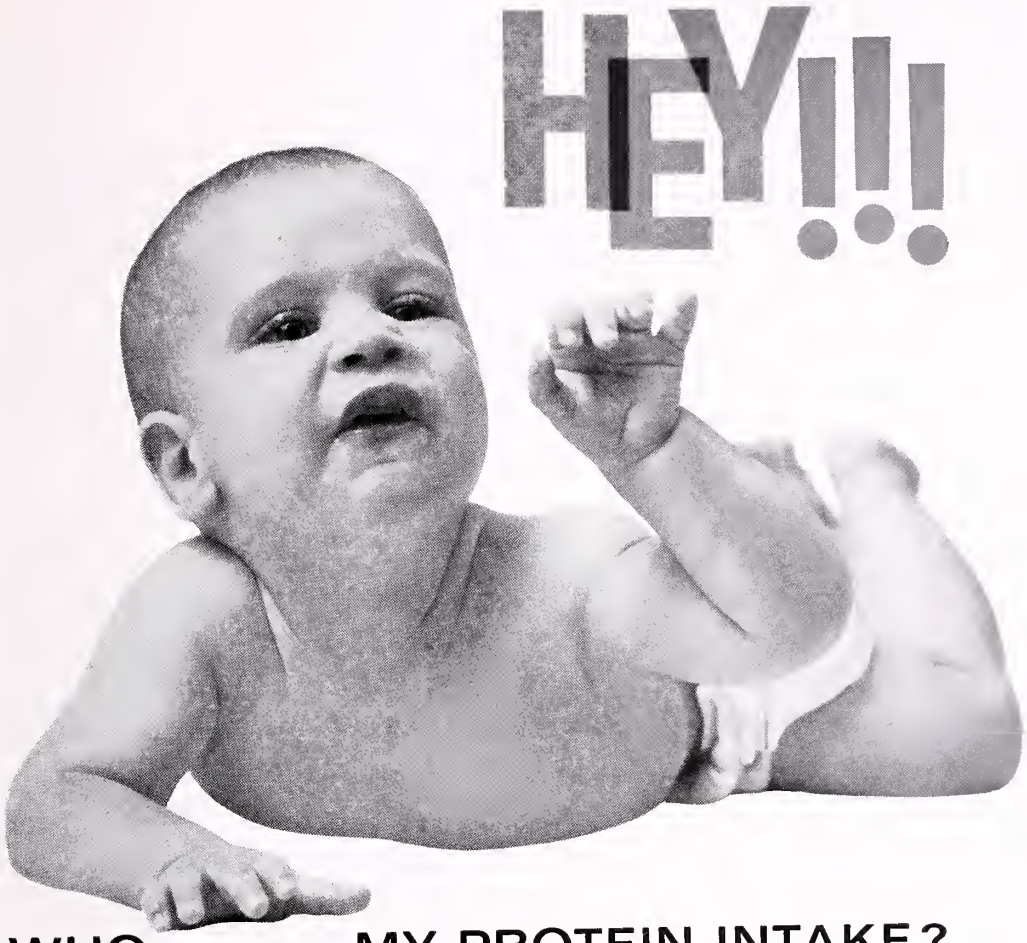
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*Lubchenco, L. O.: Formulas and Nutrition, Am. J. of Nursing 61:73 (May) 1961.



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References: (1) Roberts, H. J.: Am. J. Clin. Nutrition *8*:817-832 (Nov.-Dec.) 1960. (2) Tullis, I. F., and Allen, C. E.: Current Therap. Res. *3*:152-159 (April) 1961. (3) Tullis, I. F.; Allen, C. E., and Overman, R. R.: Simple Effective Weight Reduction: A Clinical Study, Scientific Exhibit, 6th Internat. Cong. Int. Med., Basel, Switzerland, Aug. 24-27, 1960. (4) Antos, R. J.: Southwestern Med. *40*:695-697 (Nov.) 1959. (5) Roberts, H. J.: J.A.M.A. *178*:352 (Oct. 21) 1961.

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Reports & Snorts

In our March-April issue we referred you to "page 0000" for a Saunders advertisement of three new books. This should have been changed on the page proofs to "page 317." Now we suggest you look on page 385 for new book on Physical Diagnosis by Major and Delp, and two new textbooks, one on Ophthalmology by Adler and the other on Obstetrics by Reid.

• • •

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• • •

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With his mouth full of bark,
"Ah sho' kin gnash oak in Ashoken!"

"In many respects mine was a good job. It paid two hundred and twenty-five dollars a week, of which two hundred and ten was withheld. I should have felt well satisfied. Almost everything in the way of social benefits was provided by the government—hospitalization, medical care, education for the children, accident insurance, fire and theft, old-age retirement, Tri-D shots, vacation expense, amusement and recreation, welfare and well-being, Christmas and good will, rainy-day resource, staples and supplies, beverages and special occasions, babysitzfund—it had all been worked out. . . . Ann never complained much, except about one thing. She found that no matter how we saved and planned, we never could afford to buy flowers. One day, when she was a bit lathered up over household problems, she screamed, 'God damn it, I'd rather live dangerously and have one dozen yellow freesias!' It seemed to prey on her mind."

E. B. WHITE:
The Morning of the Day They Did It
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• • •

". . . in the criticism leveled at the pharmaceutical industry too little notice, we suggest, is taken of the risks to which the industry is subjected, and too little emphasis is placed on its needs for profits, not only from purely business considerations, but also for money to plough back into research."

—British Medical Journal

• • •

". . . our apostles of affluence propose coast-to-coast spending schemes that offer too little to those who need it and a dividend to those who don't. This is very much like the legend of the eccentric who leaves a million dollars to be distributed in $1 bills to one million people. A fortune is spent, but nobody is richer. When the fortune spent is public money, everybody is that much poorer."

—AUSTIN SMITH, M.D.

• • •

In the Douay version of the Bible, the familiar sentence, "My cup runneth over," in the 23d Psalm, is translated in a delightfully different way. There it reads as follows: "My chalice which inebriateth me, how good it is!"

• • •

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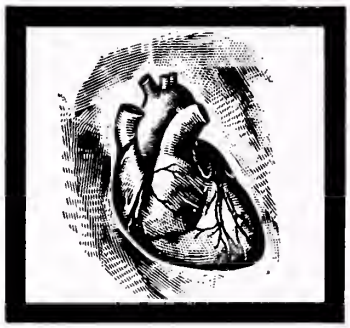
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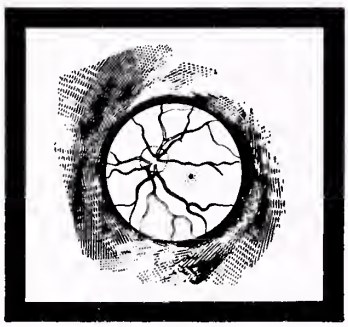
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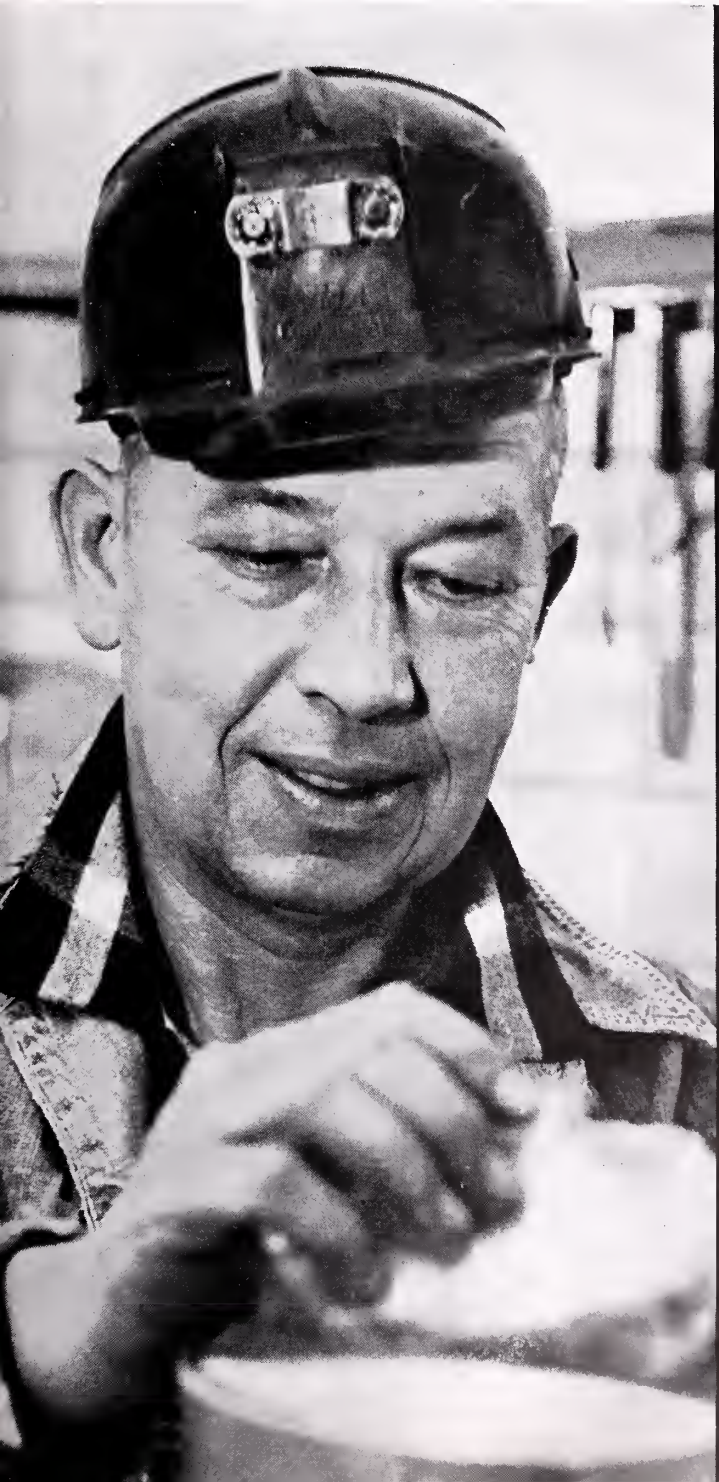
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Some Characteristics of "Swimming Pool" Disease in Hawaii

H. H. WALKER, M.D., M. F. SHINN, M.T., M. HIGAKI, B.S., and J. OGATA, B.S., *Honolulu**

• *Mycobacterium balnei has been cultured from the tissue in 8 cases of a chronic infectious granuloma of the skin which had previously been regarded by Honolulu dermatologists as tuberculosis verrucosa cutis. It seems clear now that it is in fact not due to tuberculosis at all. The epidemiologic implications are discussed.*

TUBERCULOSIS of the skin, in one form or other, has been diagnosed from time to time in Hawaii. Certain chronic indurated skin lesions of a warty, crusted, or verrucous nature on the extremities, usually knees or hands, were considered to be tuberculosis verrucosa cutis. The diagnosis was made, as a rule, on the basis of clinical appearance and histological picture of tuberculoid granulomas. At times, a few acid-fast organisms microscopically indistinguishable from tubercle bacilli might be seen on the slides. The PPD tuberculin test was frequently positive without evidence of tuberculosis elsewhere in the body.

Anti-tuberculous chemotherapy usually resulted in complete healing of the lesions. Thus the tuberculous nature of the process seemed reasonably certain. However, the most important diagnostic criterion was usually absent, namely, the ability to culture tubercle bacilli from biopsied specimens.

* From Leahi Hospital, Honolulu, Hawaii.
Received for publication November 1, 1961.

"SWIMMING POOL" DISEASE IN SWEDEN

The Swedish investigators, Linell and Norden,[1] have shown that the causative agent of a new disease entity, "swimming pool" disease, was an acid-fast bacillus which they described and named Mycobacterium balnei. They linked infection with abrasions on the outer aspect of the elbows of swimmers in a single pool in Sweden. The water and sides of this swimming pool readily yielded cultures of M. balnei.

Prior to the work of Linell and Norden, other authors had described skin lesions apparently acquired in swimming pools (Hellerstrom,[2] Cleveland,[3] Bruck,[4] Tolmach and Frank,[5] Rees, and Bennett.[6] With the exceptions of Hellerstrom and Bruck, who claimed to have cultured tubercle bacilli from lesions associated with swimming injuries, none of these authors was able to isolate an organism. It would appear now that M. balnei was the most likely causative organism in these reported cases.

The use of techniques described by Linell and Norden have enabled workers in several parts of the world to isolate M. balnei from skin lesions usually acquired from swimming pools in single instances or in epidemics. The largest number of cases thus far reported arose from a single outdoor swimming pool in Glenwood Springs, Colorado (Cleere, Mollohan, and Romer,[7] Schaefer and Davis[8]).



FIG. 1.—*Case 3. Extensive lesion on the right knee present for about 45 years showing extensive scarring and scattered nodules.*



FIG. 2.—*Case 4. Heavily encrusted verrucous lesions on the right knee present for about 6 years.*

STUDIES IN HAWAII

In the course of cooperative studies in Hawaii on mycobacteria other than the tubercle bacillus,* it was deeided to investigate verrucous skin granulomas, using the techniques of Linell and Norden, in an attempt to discover the causative organism. The bacteriological work was done at the Leahi Hospital laboratories. We are greatly indebted to the physicians in Hawaii who supplied 14 biopsy specimens for study together with clinical and other data. From eight of the specimens, bacteriological cultures of M. balnci were grown.

This report will deal with the preliminary findings in these eight cases of skin granulomata in humans caused by M. balnei, with brief data on the site and nature of the skin lesions, the characteristics of the organism, its pathogenicity in laboratory animals, and epidemiologic findings to date.

CASE REPORTS

Although an effort was made to obtain as much information as possible, unfortunately the data received were often very sketchy. The characteristic features of the organism, M. balnei, isolated from each of the following cases will be described briefly in the discussion which will follow.

CASE 1. A Filipino man, age 30, a resident of Oahu, presented encrusted arcuate granulomatous lesions about 3 inches in diameter on both knees, said to have been present for about four years. Source of infection was thought to have been from reservoirs on the island of Oahu. A fresh biopsy specimen from skin lesion on right knee was submitted for study on February 27, 1959. The result of treatment with "penicillin injections" is not known.

CASE 2. A Japanese man, age 29, a resident of Molokai, had a soft fluctuant tender swelling over the dorsum of the left index finger, said to have been present for at least four months. The source of infection was not known but was possibly connected with work at his home farm. His general health was good. Repeated tuberculin tests were negative. X-ray and physical examination of the chest were negative. Following surgical incision and drainage of the swelling, drainage material was submitted for study on January 30, 1959.

The patient was treated with streptomycin and isoniazid, resulting in complete healing of the lesion.

CASE 3. A Hawaiian man, age 73, a resident of Kauai, had a lesion covering the anterior surface of the right knee, consisting of extensive scarring with scattered rather large nodules located for the most part at the periphery of the scarred area (Fig. 1).

The patient stated that the lesions had been present for about 45 years. Onset followed a fall from a horse-drawn wagon in the hilly regions of Kauai, into a cactus plant. He recalls that a "pimple" on the right knee slowly increased in size and spread in all directions. The skin lesion came to the attention of the referring physician when the patient was admitted to Mahelona Hospital on the island of Kauai for the treatment of moderately advanced pulmonary tuberculosis. A fresh biopsy specimen from one of the nodules was submitted for study in July, 1959.

Following treatment for the skin condition with "antituberculosis drugs" and potassium iodide, the entire involved area on his knee completely healed, leaving only a deeply pigmented but perfectly flat scar. Also, when last reported, his pulmonary tuberculosis was inactive following prolonged hospitalization and chemotherapy.

Because of many possibilities of exposure, the origin of infection cannot be definitely ascertained, despite the fact that he attributed the onset to an accident in the foothills. At various times, he had worked as a cowboy, teamster, laborer, pipefitter, or garbage collector. He had a small home garden and also worked with flowers and tree planting. He had fished in the sea throughout his lifetime and also hunted wild pigs in the mountains.

CASE 4. A Samoan woman, age 22, was first seen in 1957. She had several fairly large, heavily encrusted, verrucous plaques on the right knee. A Honolulu dermatologist made a diagnosis of tuberculosis verrucosa cutis and referred her to Leahi Hospital for treatment.

The patient stated that in about 1951 when residing on Wake Island, she fell on a beach and "skinned" her right knee. About a month later, a small warty nodule appeared within the slowly healing abraded area, and gradually grew larger. She had never been in a swimming pool

* Supported by grants from the Ford Foundation and the Oahu Tuberculosis and Health Association. Cooperating agencies: Leahi Hospital, Honolulu; Hawaii State Department of Health; Hawaii State Department of Agriculture; and University of Hawaii.



FIG. 3.—*Case 5. Confluent nodules on the right knee present for about 8 years.*

but was accustomed to swimming in the ocean in Samoa, Guam, and Wake Islands.

She was found to have no evidence of tuberculosis or other significant disease. Following a brief period of hospitalization, she was discharged on combined interrupted streptomycin and isoniazid. In a few months, her lesions had almost completely healed, whereupon she voluntarily discontinued treatment and failed to return for follow-up. In September, 1959, she was readmitted to Leahi Hospital for biopsy and treatment of recurrence of lesions on the right knee, which were now more extensive and wartlike in appearance (Fig. 2).

During the second hospitalization in September, 1959, antituberculous chemotherapy consisting of streptomycin and isoniazid was reinstituted and by March, 1960, the lesions had completely healed.

CASE 5. A Japanese man, age 34, living on Maui, presented confluent nodules on the right knee, present for about 8 years (Fig. 3). The patient stated that he had "skinned" his right knee and that, before it completely healed, there appeared within the area small papules which gradually increased in size and became confluent. The lesions had been fairly stable for the past two to three years. One of the nodules was biopsied and submitted for study on November 12, 1959. A nodule about 1 cm in diameter had developed more recently on the lateral aspect of the left calf. He was not certain how he had acquired the abrasion, but he was a sugar plantation laborer who worked in an irrigation area where his legs were frequently exposed to irrigation-ditch water. Patient also did a great deal of ocean fishing and swimming, but could not relate the onset of the lesion to exposure or trauma while engaged in these sports. His general health had always been good. He had been exposed on frequent occasions to an uncle who died of pulmonary tuberculosis in 1951. However, the patient showed no evidence of pulmonary tuberculosis on x-ray or physical examination. An intermediate-strength PPD tuberculin test was slightly positive (2 mm induration).

Last report from the referring physician indicated that the lesions had completely healed after a prolonged treatment with injections of streptomycin.

CASE 6. A Filipino man, age 18, resident of Maui, presented dark bluish, raised, encrusted nodules in a cluster about 6 cm in diameter on the dorsum of the right hand (Fig. 4). A similar lesion about 3 cm in diameter was on the right forearm. The lesions had been present for about six months and, according to the patient, began with small red papules over the knuckles of the right hand. He recalled no cuts or abrasions preceding the onset of



FIG. 4.—*Case 6. Lesion on the dorsum of the right hand present for about 6 months.*

the papules, but did admit to swimming and skin diving in the ocean.

Tuberculin skin test and chest x-ray were reported to have been negative within recent months. General health was good. Family history was negative except for mother, whose chest x-ray was indicative of questionable inactive chronic pulmonary tuberculosis.

When last reported by the referring physician, the patient's lesions were clearing satisfactorily on injections with streptomycin.

CASE 7. A Filipino man, age 41, had lived on Maui since his arrival from the Philippine Islands in 1946. In September, 1960, a slightly tender lump had appeared over the dorsum of the base of the right middle finger. In February, 1961, this was incised and drained. Direct smears of the drainage material were reported to be "tuberculous." However, cultures showed a "rapidly growing acid-fast bacillus not characteristic of tuberculosis."

Incision and drainage was repeated in early March because of spread of the infection. At this time a fresh biopsy specimen was submitted to Leahi Hospital for study. A pathological report at this time stated that the histopathology was "acute and chronic exudative inflammation with focal abscess formation, but without any evidence of tuberculosis, possibly because the underlying histopathology had been obscured by secondary infection."

A more recent, smaller nodular lesion over the extensor tendons of the right middle and ring fingers, according to the patient, was similar in appearance to the larger lesion at its onset.

General health was good, and there was no evidence of pulmonary tuberculosis. The patient was a field worker on a sugar plantation, doing field work and installation of irrigation flumes. There was no other pertinent occupational history. On September 11, 1961, a second-strength PPD tuberculin test gave a 35 mm reaction. At the same time, a skin test with M. balnei antigen gave a reaction of 28 mm.

At the time of last report, the referring physician stated that the lesion was responding well to streptomycin intramuscularly.

CASE 8. A Caucasian-Hawaiian man, age 38, had a slightly elevated, non-tender, dry, finely granular, scaling

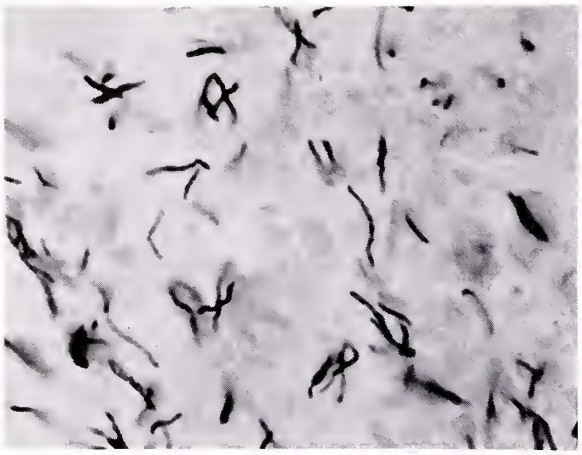


FIG. 5.—*Acid-fast bacilli showing "cross-barring", smear from mouse inoculated with culture from Case 3. (x1200)*

area approximately 2 cm in diameter on the posterolateral ulnar side of the right wrist, present for about six months. He attributed the onset to an abrasion sustained while skin diving on Kwajalein Island of the Marshall group in the Pacific. Small papular lesions appeared in this area which at first were covered with a yellowish exudate but eventually dried and crusted. There was no itching or pain although the patient stated that the presence of the lesion bothered him and he was accustomed to pick at it.

He was born and raised on the island of Oahu, but from 1945 on had made frequent trips to the islands of Midway and Kwajalein. He was a plumber, and as such he had contact with many soils, swimming pools, reservoirs, and drainage ditches. As an avocation, he had engaged in fishing since early teenage, particularly with throw net or skindiving.

Upon his return to Honolulu in December, 1960, he was seen by a physician who biopsied the lesion. A diagnosis of tuberculosis verrucosa cutis was made by a local pathologist on the basis of the histologic picture, although no acid-fast organisms were seen. No treatment was received at this time. On May 2, 1961, the patient was admitted to Leahi Hospital for biopsy and study. His history and physical examination were essentially negative. His general health had always been good. Chest x-ray showed no evidence of pulmonary tuberculosis. Intermediate-strength PPD tuberculin test gave a 20 mm reaction at the end of 48 hours. There was a 15 mm reaction to M. balnei antigen.

During his brief period of hospitalization in May, the entire nodule was excised for study and he was started on treatment consisting of streptomycin and isoniazid. This was continued on an outpatient basis for some months. There has been no recurrence of the lesion.

DISCUSSION

The Organism. In each of these 8 cases, acid-fast bacilli were grown from fresh biopsy specimens. The organisms have been identified as M. balnei as described by Linell and Norden.[1] The characteristics of this bacillus readily distinguish it from the tubercle bacillus as well as from other acid-fasts. Briefly, the distinctive features of M. balnei



FIG. 6.—*Mouse inoculated intraperitoneally with culture from Case 1, showing typical "bumpy" tail.*

are: its rapid growth (two to three weeks) on solid egg medium at 31° C. in contrast to 37° C., the optimum temperature for the tubercle bacillus; differences in macroscopic morphology of the colonies, especially photochromogenicity, changing from creamy white to light yellow to orange when exposed to light; primary resistance to one or more of the anti-tuberculous drugs, usually completely to para-aminosalicylic acid (PAS) and partially to streptomycin (SM) and isoniazid (INH); a high degree of pathogenicity in mice (Figs. 5 and 6), in contrast to little or none in guinea pigs, although in some instances the latter become sensitized to culture filtrates or to human tuberculin.

The M. balnei cultures isolated in Hawaii have been compared with some of the Swedish strains and also have been sent to other laboratories for study. Schaefer and Davis[8] studied four of the Hawaii cultures and reported them to be almost identical with the strain of M. balnei which had been isolated from the outdoor swimming pool in Glenwood Springs, Colorado.

Histopathology. Biopsies on some of the 8 cases had been submitted on occasion to different pathologists in Hawaii for histological examination. Their reports were quite varied and included "chronic inflammatory lesions," "granulomas of the skin," "granulomatous dermatitis," or "consistent with tuberculosis verrucosa cutis." Occasionally a few acid-fast organisms were seen on the sections. No positive cultures were reported except in Case 7, in which a rapidly growing organism was cultured.

There was considerable variation in the histopathology of the 8 cases. This was likewise found to be true of the cases reported by Linell and Norden[1] and Schaefer and Davis.[8] The variations seemed to be largely dependent upon the age of the lesions or the presence of superimposed infection by staphylococcus or other secondary organisms. Dr. Emil Bogen reviewed the histological slides of some of the cases and commented as

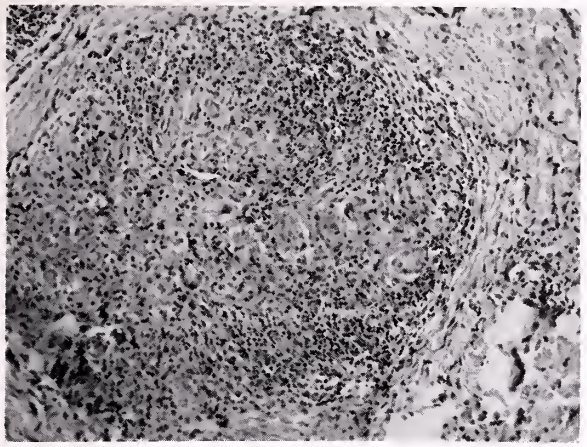


FIG. 7.—*Granuloma with giant cells and epithelioid cells in the center and lymphocytes at the periphery. (x160)*

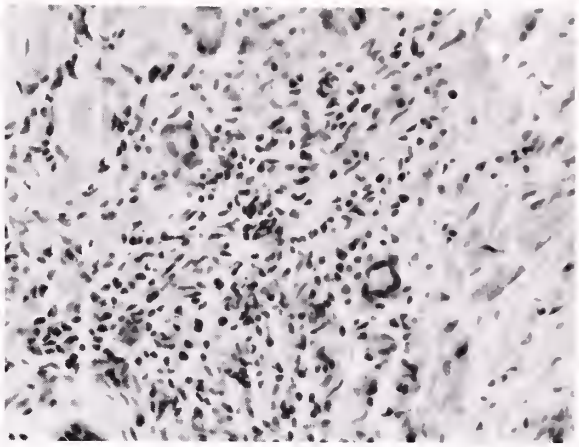


FIG. 8.—*Small scattered giant cells in a nondescript infiltrate in the derma. (x600)*

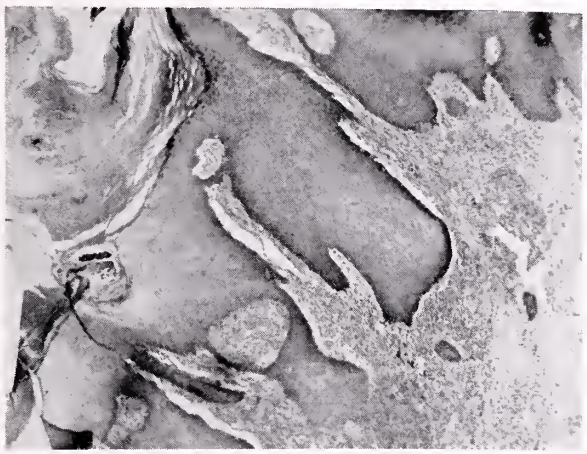


FIG. 9.—*Low power photograph showing marked parakeratosis, hyperkeratosis and acanthosis in the epidermis. (x40)*

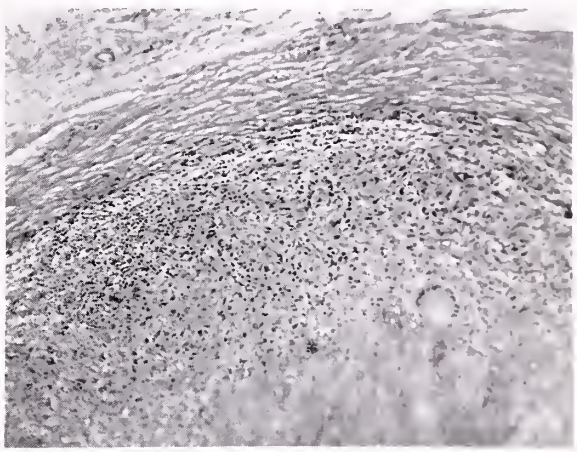


FIG. 10.—*Lesion with large abscess. Photograph shows portion of the caseous necrosis at the lower right, above which is part of the surrounding granulomatous band containing epithelioid cells and giant cells and at the top a "capsule" of fibrous tissue. (x140)*

follows: "The histological appearance of chronic granulomatous infiltrate just below the epidermis and around superficial blood vessels, with epithelioid cell tubercles and giant cells (Figs. 7 and 8), and the parakeratosis, hyperkeratosis, and acanthosis in the epidermis (Fig. 9) are consistent with the findings of other workers. There was more nonspecific acute and subacute subcutaneous inflammation and abscess formation in some of the cases than in those described by Linell (Fig. 10). These may have been due in some instances to secondary infection, but similar lesions have been produced by the inoculation of M. balnei into mice."

Linell and Norden,[1] in commenting on these variations in histology, made the provocative statement that "in cases of granulomatous inflammation of the skin, histological examination is by itself not sufficient for establishing a diagnosis of tuberculosis even if acid-fast bacilli can be demonstrated in sections."

The Gross Skin Lesions. In contrast to the appearance of the lesions as described by Linell and Norden[1] in the Swedish epidemic, and Schaefer and Davis[5] in the Colorado epidemic, and the almost uniformly characteristic location on the elbows, the lesions in the Hawaii cases varied considerably in appearance (Figs. 1, 2, 3, 4). Further-

more, none of them was located on the elbow. In four of the cases, the site of involvement was one or both knees, in three the dorsum of one or both hands, and in one the ulnar side of the right wrist.

In Case 8, the relatively early lesion most closely resembled those typically seen by Linell and Schaefer. Case 3 had the most extensive involvement and likewise had a history of longest duration—45 years.

Cases 2 and 7 were unusual: both had a fluctuant abscess (dorsum of the first left finger in Case 2, and dorsum of the right middle finger in Case 7). The referring physicians in both instances reported that at the time of surgical incision and drainage, there was no evidence of bone involvement although possibly some superficial involvement of the extensor tendon sheath. In general, the most heavily encrusted or fungating lesions were those in which secondary infection by staphylococcus or other organisms was superimposed.

There were other interesting features in the Hawaii cases: all but one were males; with one exception (Case 3) whose age was 73, all fell within the age distribution of 18 to 41; there was considerable racial variation, three being Filipinos, two Japanese, one Hawaiian, one Caucasian-Hawaiian, and one Samoan; the duration of the lesions varied from three or four months to a maximum of 45 years, with half of the cases falling within a period of six months or less.

Possible Sources of Infection. The epidemiologic data on the 8 Hawaii cases are obviously insufficient to permit any definite conclusions. Some of the data, however, were suggestive enough to indicate possible sources of infection. Some of these leads are currently being investigated.

It would appear that M. balnei is of widespread distribution in the Hawaiian Islands and possibly in other islands of the Pacific. In two of the cases (Cases 4 and 8), the histories suggested that the lesions were acquired in areas other than Hawaii. In Case 4, the lesion possibly developed following an abrasion on the knee on a Wake Island beach. However, this individual had also lived in American Samoa, California, Guam, and Hawaii. In Case 8, although the individual was a plumber who worked on the island of Oahu, in Hawaii, he also worked on Midway and Kwajalein in the western Pacific. The man was reasonably certain that he had acquired the infection following an abrasion on his wrist while skin diving for black coral on Kwajalein Island. In both instances, the organism might have been present in salt water. With the possible exception of one case (Case 6), none of the cases gave a history at all suggestive of swimming pools as a source of infection.

It is not believed that race is of significance other than from the standpoint of occupation. In a majority of the cases, there was suggestive evidence that the lesions were acquired in the course of their work in soils on sugar or pineapple plantations or from fresh water reservoirs or irrigation ditches on these plantations. In some cases, the history of salt water fishing of one sort or another was obtained, but in none of these did the individuals attribute the onset of their lesions to these activities.

At the present time, little is known of the prevalence and distribution of the organism other than its presence on four of the islands in the Hawaii group. It is obviously of practical importance to determine, if possible, how and where M. balnei infections of the skin are acquired. Undoubtedly, there are other cases of skin lesions due to M. balnei in the Islands and it is hoped they will be discovered by local physicians so that additional material may be obtained for study and more epidemiologic data gathered.*

The need for determining the prevalence and distribution of this organism is very great, because it, like other unclassified mycobacteria, is known to be capable of inducing sensitivity to tuberculin. Whereas the tuberculin test at one time was considered to be highly specific for tuberculosis, it has been shown in recent years that there exist in nature a number of acid-fast organisms which produce low-grade nonspecific tuberculin reactions, particularly in certain geographic areas. A rather high incidence of low-grade reactions has been found in tuberculin surveys conducted in recent years in Hawaii. Furthermore, local veterinarians find that occasionally there are low-grade tuberculin reactions in cattle in which no evidence of tuberculosis can be found after they are slaughtered. Thus the possibility of sensitization of both humans and cattle by acid-fast organisms other than the tubercle bacillus would appear to be quite likely.

With the realization of the need for greater knowledge of the prevalence, distribution, natural history, virulence, and sensitizing potentials of these unclassified mycobacteria in Hawaii, Leahi Hospital, in cooperation with the professional staff of the State Department of Agriculture, has begun to collect specimens of fresh and salt water and soils from the different islands. From over 100 specimens, about 30 strains of mycobacteria have been isolated to date. Work has started on their identification and the determination of their various properties, especially with respect to their pathogenicity and sensitizing properties in man and animals.

* Physicians who encounter chronic nodular skin lesions resembling those reported in this paper are requested to contact Dr. Walker at Leahi Hospital by telephone or letter for instructions regarding biopsy, photography, and epidemiologic data desired.

SUMMARY

Eight cases of chronic granulomatous skin disease in Hawaii due to infection by Mycobacterium balnei are described. The lesions differed widely in appearance, mode of onset, anatomical sites, and duration from those usually seen in "swimming pool" disease caused by infection with M. balnei elsewhere. The histologic picture, though quite varied, was consistent with the histopathological manifestations of the latter disease. The bacteriological characteristics were identical with those originally described by Linell and Norden,[1] who discovered and named the organism.

The natural history of the skin lesions is discussed briefly and some thoughts expressed as to possible sources of infection and other epidemiologic features. Particular attention is directed to the fact that, with one possible exception, there was no evidence that the infection had been acquired from swimming pools. It would seem likely that isolated instances of M. balnei skin infections derived from sources other than swimming pools are being overlooked in other regions. That M. balnei (which is widely distributed in Hawaii) as well as other acid-fast organisms can induce sensitivity to tuberculin is well established. Thus it may play an important role in the production of a rather high incidence of low-grade tuberculin reactions in humans and cattle.

Studies are being conducted to determine the prevalence, distribution, and characteristics of the various mycobacteria other than M. tuberculosis. ●

ACKNOWLEDGMENT

The authors wish to thank the many professional colleagues, technicians and others who contributed in one way or other to the studies. Unfortunately, it is not possible to name all of these individuals. We are particularly grateful to the unnamed group of physicians and consulting dermatologists who found the eight cases and submitted the biopsies and data and other information which have made this paper possible. We are also grateful to the pathologists who so generously shared their histological slides and reports with us.

The following individuals deserve special mention because of the major roles which they played in the studies: Dr. Seymour Froman, consultant from Olive View Sanatorium, California, who participated in the bacteriological work on the earlier cases; Dr. Emil Bogen, former bacteriologist and pathologist at Olive View Sanatorium, who for the past six months has directed the research investigations on mycobacteria at Leahi Hospital; Gordon Wallace and John Gooch, Doctors of Veterinary Medicine, associated with the State Department of Health in Hawaii, for their cooperation, advice, and assistance in performing the major portion of the field work involved in the collection of water and soil samples for culture; Dr. Ernest Willers, Director, Division of Animal Industry, Hawaii Department of Agriculture, and his professional staff who played a very active role in the animal studies; Mr. Sidney Kansako, special research technician on mycobacteria, and the other technicians of Leahi Hospital who contributed so much to the bacteriological investigation; Dr. Mogens Magnusson of the Seruminstitut, Copenhagen, for furnishing M. balnei antigen for skin testing (he is at present studying the Hawaiian strains of M. balnei); Werner Schaefer and Charles Davis for their comparative studies on the Hawaiian and Colorado strains of M. balnei; and Dr. Irvin L. Tilden who made many of the photomicrographs.

Finally, we wish to acknowledge the generous grants received from the Ford Foundation and the Oahu Tuberculosis and Health Association, which have made these studies possible.

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A Hawaiian "first"—maybe one of your cases of hypertension is a potential "second?"

Primary Hyperaldosteronism Due To Left Adrenal Adenoma

Report of a Case

FRED I. GILBERT, JR., M.D., *Honolulu*

• *If hypertension is accompanied by alkaline urine of persistently low specific gravity, blood electrolyte studies should be done to see whether the hypokalemic alkalosis of hyperaldosteronism is present. If it is, laparotomy is in order, to look for an adrenal adenoma.*

PRIMARY hyperaldosteronism is a curable disease characterized by excessive production of aldosterone by adenoma, hyperplasia, or carcinoma of the adrenal gland. The majority of cases by far have been due to an adrenal adenoma.[1] The first case and the major clinical and laboratory features were described by Dr. Jerome Conn in 1955.[2]

THE DISEASE IS RARE

The disease is rare, but there are probably half a dozen or more unrecognized cases of it in Hawaii. It masquerades as ordinary hypertension, with no external distinguishing features. Although aldosterone increases urinary loss of potassium with retention of sodium, it is obviously not practical or advisable to perform blood electrolyte studies on all hypertensive patients to determine the presence of hypokalemic alkalosis.

From the Medical Department of the Straub Clinic.
Received for publication Sept. 1, 1961.

MUST BE SUSPECTED

However, few cases will be missed if the urine is noted for alkalinity and low specific gravity. If, for example, the urine of a hypertensive patient has a pH of 7.2 and a specific gravity of 1.010, the physician should permit himself to become mildly excited, and question the patient closely about episodes of muscular weakness, hyperventilation-like symptoms with paresthesias, dry mouth, or excessive thirst. Whether these symptoms are present or not, repeat urinalysis should be performed after dehydration, and if the specific gravity remains in the vicinity of 1.010, blood electrolyte studies are in order.

The following case is the first to be diagnosed and treated in Hawaii, and is also the first known case in which 36 holes of golf on a warm weekend played a major role in establishing the correct diagnosis.

CASE REPORT

A healthy-appearing man of Korean extraction, 42 years old, was first seen in 1954. He had no symptoms, but his blood pressure was 200/110. Physical examination was negative, apart from mild arteriosclerotic retinopathy and a congenital cataract of his right eye. The history revealed that high blood pressure was first noted in 1952 during the course of a life insurance examination. After his blood pressure had been rechecked several times, he was found to be insurable.

His family history was unusual. Although his parents were relatively long-lived, his father dying of a stroke at 75 and his mother alive and well at 68, all of his siblings had died young. Of three brothers, one died at the age of nine of "enlarged kidneys," and two died of unknown causes as young adults. A sister died of uremia attributable to polycystic kidney disease, although no autopsy was performed.

The patient's own health had always been good and, except for nocturia three to four times nightly for as long as he could remember, system review was negative. The family history of fatal renal disease pointed to the kidneys as perhaps being responsible for the hypertension. An intravenous pyelogram, however, revealed no abnormality except for poor concentration bilaterally. Two attempts to concentrate his urine by overnight dehydration resulted in specific gravity of 1.010 and 1.008, and pH of 7.6 and 8. The urine was negative for protein and sugar, and examination of the sediment showed no abnormal findings. An EKG and chest x-ray were normal, and a blood count and urea nitrogen determination were within normal limits. The blood cholesterol was 248 mg per cent.

Over the next few years he received reserpine, 0.1 mg at bedtime, and phenobarbital, ¼ gr. t.i.d. The patient remained asymptomatic, with the blood pressure ranging from 160/108 to 170/120. On the few occasions when he was not receiving medication for several weeks at a time, his blood pressure rose as high as 210/130.

On March 15, 1960, he was seen with the unusual complaint that his steps were getting shorter. He had played 36 holes of golf on the previous weekend, and on the final nine, he noted that he was taking extremely short steps. This gave him no great concern because his game was reasonably good, but the next evening, after walking about with his shortened stride, he felt generally tired and noted weakness of his left hand and difficulty in controlling the fingers of his right hand. When pressed, he admitted to a mild attack of weakness of both legs in January, 1960, which promptly improved after osteopathic manipulations.

Physical examination showed the patient to be alert and cooperative. His blood pressure was 170/120; the sensory status was normal. His grip was strong in both hands, but he was unable to elevate his arms above the horizontal position (Fig. 1). There was marked weakness of the left leg, but only minimal weakness of the right. The only abnormal reflexes were absence of the left ankle jerk and a greatly diminished left knee jerk.

Laboratory findings: potassium, 2.4 mEq/l; sodium, 165 mEq/l; chlorides, 98 mEq/l; CO_2, 37.3 mEq/l; and urea nitrogen, 14.4 mg per cent. The EKG at this time showed changes compatible with hypokalemia. On March 22, 1960, a perirenal CO_2 insufflation was carried out, and



FIG. 1.—*Photograph of patient before treatment. He is unable to raise his hands above the horizontal position.*

the x-rays showed adrenals of normal size; the left was slightly larger than the right. On March 25, 1960, a left adrenalectomy was performed by Dr. Walter Strode, after a firm nodule in the adrenal, thought to be about one cm. in diameter, was palpated. The right adrenal was explored and found to be normal. A needle biopsy of the left kidney was performed. Pathologic examination by Dr. W. Harold Civin showed an adrenal gland, which weighed

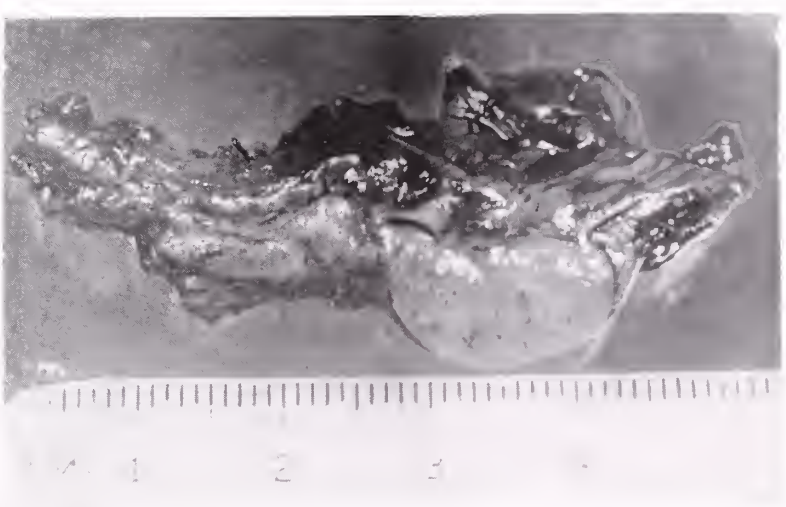


FIG. 2.—*Gross specimen showing adenoma of left adrenal. It had a bright yellow color and was arising from one side of the cortex in the middle of the gland.*

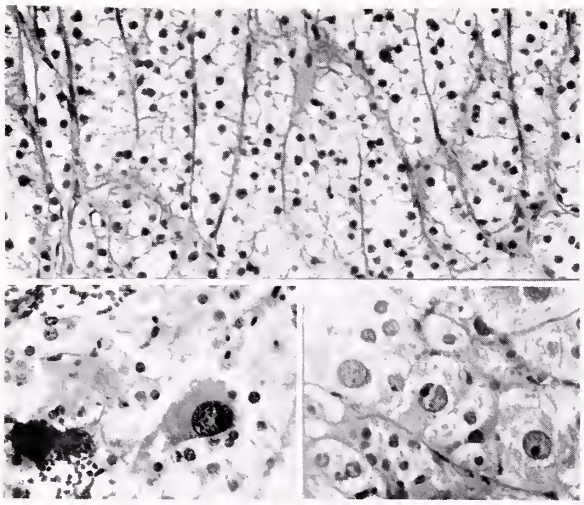


FIG. 3.—*Photomicrograph showing normal adrenal cortex (zona fasciculata) above, and two views of the adenoma (below). Note the variation in the size of the cells and nuclei, and the cell atypism shown by hyperchromatism and prominent nucleoli. The tumor was regarded as benign. Hematoxylin and eosin. (x265)*

six gm., surrounded by periadrenal fat. Bulging from the central part of the gland was a bright yellow nodule measuring 1.6 x 1 x 1 cm. (Fig. 2). This was sharply demarcated from the neighboring adrenal tissue which presented a well-defined, normal-appearing cortex and medulla upon sectioning.

Microscopically, the adrenal tumor was composed of sharply-outlined, lipid-filled cells which varied greatly in size (Fig. 3). They were arranged in nests and cords, and cellular atypism was prominent, there being a number of very large cells showing hyperchromatism and prominent nucleoli. Despite the cellular atypism, the tumor was regarded as a benign adenoma.

The renal biopsy showed vacuolization and fraying of the cells lining the proximal convoluted tubules; this was thought to be compatible with the vacuolar nephropathy found in hypokalemic states (Fig. 4). There was no significant nephrosclerosis.

Convalescence was uneventful. Four months after surgery, on July 25, 1960, the patient was asymptomatic and had not been on medication. His blood pressure was 152/116. He still had nocturia twice nightly in contrast to the previous three to four times a night. He played 18 holes of golf without symptoms, but has not yet had time for the therapeutic trial of 36 holes.

The blood electrolytes were as follows: sodium, down from 165 to 145 mEq/l; potassium, up from 2.4 to 4.9 mEq/l; CO_2, down from 37.3 to 19.3 mEq/l; and chlorides unchanged, at 101 mEq/l. Examination of the first voided urine in the morning showed a pH of 6, and a specific gravity of 1.012.

CONCLUSIONS

The persistent hypertension, though at a lower level than previously, may be due to long-standing hypertension with arteriolar nephrosclerosis (despite the minimal changes in the needle biopsy of the kidney).

On August 4, 1961, he looked and felt well. He had nocturia one to two times. Blood pressure was 144/104 on reserpine, 0.1 mg twice a day. Urine showed a pH of 6.0, specific gravity of 1.020, and protein, sugar and sediment negative, after overnight dehydration.

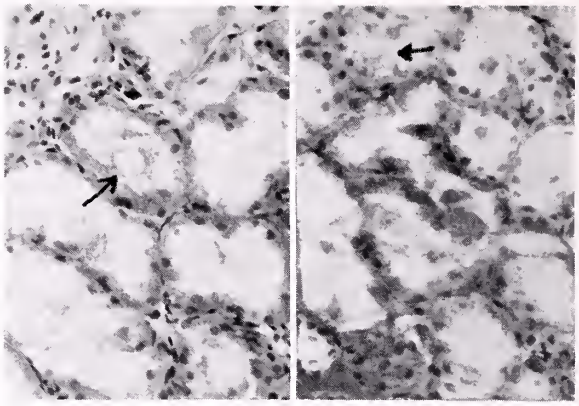


FIG. 4.—*Photomicrograph showing two views of the kidney. The fraying and vacuolization of the cells (arrows) lining the proximal convoluted tubules was thought to be compatible with the vacuolar nephropathy of hypokalemia. There was no significant arteriolar sclerosis. Hematoxylin and eosin. (x265)*

Urine assay for aldosterone on preoperative specimens was reported to be within the normal range. Other studies carried out prior to surgery consisted of attempted aldosterone antagonism with spironolactone and analysis of potassium and sodium secretion in saliva and urine. These studies did not contribute to the diagnosis. The adrenal with the adenoma was frozen and sent to the University of California for aldosterone assay. E. G. Biglieri, M.D., of the Metabolic Research Unit and the Department of Medicine of the University of California, San Francisco, reported the following results:

Normal part of the adrenal:		
Cortisol	10	mcg per gram
Corticosterone	3.6	" " "
Aldosterone	0.33	" " "
Tumor:		
Cortisol	6.0	mcg per gram
Corticosterone	11.1	" " "
Aldosterone	0.98	" " "

These figures revealed an approximate three-fold elevation of both corticosterone and aldosterone in the tumor over and above the levels of the unaffected gland, which are also those of normal adrenals. ●

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At least one kind of mental retardation is preventable.

You should be on the lookout for it.

Phenylpyruvic Oligophrenia

FRANK L. TABRAH, M.D.,* *Kohala*

• *Physicians should test all babies at between 3 and 8 weeks of age for phenylketonuria, by putting 10% ferric chloride on a wet (or dried) diaper and looking for the blue-green to gray-green color. If blood phenylalanine is then found to be high, it is of the utmost importance to place the infant on a low phenylalanine diet in order to prevent serious mental retardation (oligophrenia).*

SURPRISINGLY, about 50 inborn errors of metabolism are known. Among the few that can be corrected, phenylketonuria was first described by the Norwegian biochemist, Folling, in 1934.[1] It is a treatable hereditary condition characterized by severe mental retardation and the presence of phenylpyruvic acid in the urine.

Over 400 cases have been studied and reported since Folling's work, and much is now known of the biochemistry of this interesting defect, generally known as phenylpyruvic oligophrenia.

About one per cent of all mental defectives in institutions have this disease. It occurs once in 40,000 births in the United States. Transmitted by a recessive gene, it may be expected to occur once in four births in a family with at least one affected child.

Although tests have been devised by Hsia and others for the discovery of heterozygous carriers of the defective gene,[2] these tests are hardly useful except as a basis for genetic counselling of affected families.

Two simple measures minimize this disease—early detection, and proper dietary management.

From a public health standpoint, the early detection of *every* case of phenylketonuria represents a major challenge to physicians and nurses caring for infants. Simple methods for screening all newborn infants at about three to four weeks of age may prevent, through treatment, the needless lifetime institutionalization of about 200 affected infants born yearly in the U.S.A. alone, a most impressive salvage, since treated children can develop normally.

The following case report suggests the need for a routine method of casefinding to be used on all young infants born in the State of Hawaii, since this patient is of *kamaaina* parents. The gene causing phenylpyruvia is apparently present in Hawaii *nei*.

Recent reports suggest that the disease may exist in minimal forms, causing only mild retardation, seizures, or assorted combinations of neurological disorders. Thus, effective screening methods, systematically applied, might have wider therapeutic application than in the prevention of idiocy.

CASE REPORT

A 3½-year-old girl was referred to Kohala Child Development Clinic for study because of severe mental retardation. She was born at term in a Honolulu hospital after an uneventful primiparous pregnancy and delivery. Her birth weight was 2.9 kg (6.4 lbs), length 48.4 cm (19 in), and head circumference 33.1 cm (13 in). She cried immediately after birth, appeared entirely normal throughout the perinatal period, and left the hospital after four days.

This normal appearing baby was breast fed for six months, had adequate vitamin supplements, was started on solids at two weeks of age, and had no recognizable illnesses during her first year. Growth and gain were excellent, in contrast to her genetic legacy, which unfortunately was not. These relationships existed:

Maternal grandmother	retarded
Maternal uncles and aunts	3 retarded 2 retarded and epileptic
Maternal cousins	1 retarded 2 retarded and epileptic 1 epileptic

When the patient was two months old, her mother suspected retardation because of slow motor development.

* Associate Plantation Physician, Kohala Sugar Company. Received for publication September 15, 1961.



FIG. 1.—*Photograph of patient at age 3½ years. Note jet black hair color.*

The child sat alone at one year, never crawled, but walked at two years. She began making guttural sounds at about two years, but has only recently said "mama."

At 3½ years, she shows the adaptive behavior, the personal-social development, and language development of a 12-month-old child. Her motor development is about at the 18-month level. On the Vineland Social Maturity Scale, her social age is nearly 1½ years, her social quotient, about 40. This girl is indifferent to friends and strangers alike, showing scant response to most situations, although she furiously resists examination.

On physical examination, she weighed 15 kg, was 91.3 cm tall, and her head was 48.1 cm in circumference. Her body proportions were normal. She appeared to be entirely normal anatomically—well developed, well nourished, her skin properly pigmented for her racial pattern. The mother is Hawaiian, Spanish, and Caucasian; the father is Hawaiian, Japanese, and Portuguese. The child's hair is richly black; she has no suggestion of skin defects, either in texture or color. (Fig. 1).

Neurological examination elicited normal reflexes. Cerebellar function seemed to be slightly impaired; mild tremors were noted in her arms, legs, and hands during one of her rages. At rest, her fingers often assumed a peculiar clawlike position which shows well in her photograph.

Laboratory findings at the time of her examination were:

	Differential count:	
WBC 11,900	Polys 29	No atypical
Hct 42%	Bands 2	cells were
Hgb 13.5 gm	Eos 2	present
	Lymphs 63	
	Monos 5	

X-rays showed her bone age to be normal, but in a low (5th-8th) percentile.

Her urine was of normal color on standing, clear, pH 5.5, sp. gr. 1.014; glucose and albumin were absent according to the Clinitest tape reaction and Robert's Reagent. However, phenylpyruvic acid was present in large amounts.

On the addition of ten drops of 10 per cent aqueous solution of ferric chloride to 2 cc of urine, a deep blue-green color developed immediately, fading but slowly during several days at room temperature. The unusual persistence of the color suggested a false positive reaction, but apparently a wide variation in stability of the blue color exists without significance, as all our specimens were unquestionably positive for phenylpyruvic acid.

A determination of her serum phenylalanine level was reported as 22 mg per cent, or about eight times normal, confirming her diagnosis.

A diet composed of foods low in phenylalanine was started, using Lofenalac (Mead Johnson) as its basis. Within a few days the child's urine no longer reacted positively to ferric chloride, suggesting at least a fair degree of control. With the cooperation of Dr. Angie Connor, Chief of the Bureau of Mental Retardation, Hawaii State Department of Health, she was admitted to Kauikeolani Children's Hospital, Honolulu, for study by Dr. Francis Nance, whose illuminating note follows:

TABLE 1.—*Low Phenylalanine Meal Plan*

Diet Prescribed: 15 Equivalents or 225 mg of Phenylalanine

MEAL PATTERN	SERVINGS	SAMPLE MENU
BREAKFAST:		
Fruit	1—List III*	Papaya .....¼ cup
Cereal	1—List IV	Frosty Flakes .....⅔ cup
Lofenalac	1—List I	Lofenalac ..... 1 cup (reconstituted)
LUNCH:		
Vegetable	2—List II	Cabbage, carrots, beans, cooked in tomato sauce.....⅔ cup
Rice	1—List IV	Rice .....¼ cup
Lofenalac	1—List I	Lofenalac ..... 1 cup (reconstituted)
SUPPER:		
Vegetable	2—List II	Potato, beets, peas, cooked in shoyu.....⅔ cup
Rice	1—List IV	Rice .....¼ cup
Lofenalac	1—List I	Lofenalac ..... 1 cup (reconstituted)

* Foods may be selected from Phenylketonuria Exchange List.

The phenylalanine test on the urine was negative on admission which showed that there was at least this much control on the diet that the mother was giving her. An initial blood phenylalanine was taken and sent to the mainland. This gave a result of 7.9 micrograms. A 24-hour urine was run with her on the diet as carried out by the mother, and during this time no phenylalanine appeared in the urine. To reconfirm the diagnosis, the child was put on two days' normal diet; phenylalanine promptly reappeared in the urine, and the blood level rose to 20 in 48 hours. She was thereupon returned to her previous diet.

Later, the dietitian of the Children's Hospital was of great assistance in expanding her diet to include easily obtainable foods that are sufficiently low in phenylalanine to keep the blood level within the acceptable range of 2 to 6 mg per cent. At present, the diet as outlined in Table I appears to be satisfactory. The "phenylketonuria exchange list" to which the table refers is available from the Bureau of Nutrition, California State Department of Health, Berkeley, California.

While she was hospitalized, an electroencephalogram was done under sedation with 100 mg Seconal, by Dr. Y. T. Wong, who reported:

> A small amount of rhythmic 10.5 per second alpha, only in the frontal leads. Many high voltage, irregular, 2-6 per second waves. Mostly bilaterally synchronous in all leads. No definite bursts. No spikes. Generalized abnormal EEG. Moderately severe.

A portion of this tracing appears in Fig. 2. Dr. John Lowrey, who also saw her in consultation, felt no further neurological studies were indicated.

Further management of this child's disease is now limited to prolonged dietary advice and provision of a sheltered existence. Her chances of mental improvement are only fair, serious damage to developing neural tissues having occurred by the time her condition was recognized. Maintenance of a low phenylalanine intake may, however, prevent further damage and reduce the probability of convulsions.

DISCUSSION

The mechanism involved in the development of phenylpyruvic oligophrenia is only partly known. L-phenylalanine, an amino acid found in protein, is converted completely, in the normal individual, to tyrosine by phenylalanine hydroxylase. In the phenylketonuric patient, part of this enzyme system is absent or inactive, causing excessive accumulation of l-phenylalanine in the blood and spinal fluid. The resulting defect in tyrosine production is often reflected in pigmentation abnormalities, eczema, and adrenalin deficiency. Excess l-phenylalanine, or related substances occurring in the blood and spinal fluid, appear to be the cause of central nervous system damage.[3]

Although ingestion of d-phenylalanine or dl-phenylalanine can cause slight phenylketonuria in normal individuals, the ability to convert l-phenylalanine to tyrosine appears to be the primary metabolic difference between the normal and the phenylketonuric individual.[4]

Central nervous system damage can be prevented in the phenylketonuric patient by limiting

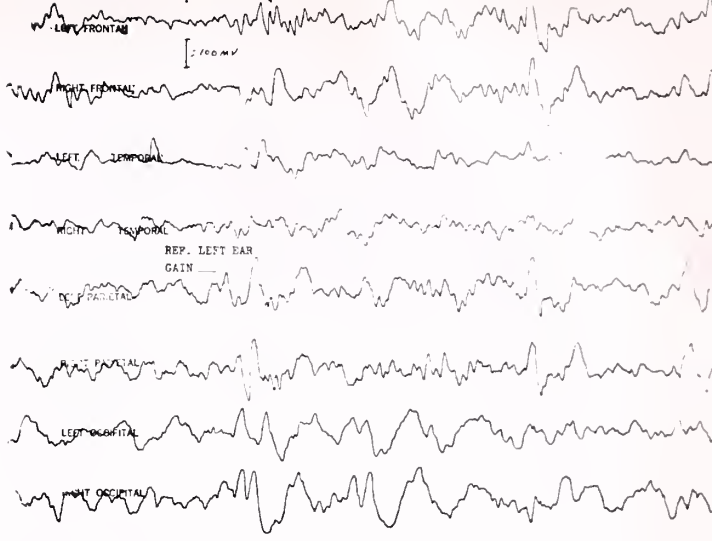


FIG. 2.—*Electroencephalogram. See text for explanation.*

phenylalanine (d-, l-, and dl-) intake sufficiently to hold the serum phenylalanine level between 2 and 6 mg per cent.

There is variation in the degree of improvement a controlled diet can achieve. Results vary with the age at onset of treatment, degree of previous damage, and the severity of the enzyme defect. There is general agreement in the literature that a low phenylalanine diet should be used for every childhood case, regardless of age or mentality, and for some adults.

W. R. Centerwall's evaluation of treatment of 10 patients[5] indicates the urgency of early (age two months) phenylalanine control to achieve normalcy, and the relatively poor result of treatment begun after six or eight months.

FIND CASES EARLY!

Because of the serious but preventable damage resulting from phenylketonuria, infant screening programs have been started in many countries. A number of simple, inexpensive, but effective methods are in use. In most cases where phenylketonuria has been discovered in very early infancy, the diagnosis had been made previously in an older sibling, sacrificing one child in each involved family. A screening program avoids this tragedy by finding phenylpyruvic children in previously uninvolved families early enough to receive the maximum benefit from treatment. W. R. Centerwall suggests testing the urine of all infants at the first three well-baby checkups, since phenylpyruvic acid does not appear in the urine until the second or third week of life, and in some cases not until six weeks.

Several methods are available for urine screening. Details of these methods are available, together with comparisons of five currently used techniques, in an article by Allen.[6]

At present, we find the "diaper test" most useful. This is a modification of the ferric chloride

test-tube test, previously described. A drop of 10 per cent ferric chloride is placed on a baby's wet (or dried) diaper. If positive, a blue-green to gray-green color appears immediately. (Acidification is not necessary as the pH of the ferric chloride is 1.8.) The color is apt to be transient. A wet diaper is not always available, but it is far more so than a urine specimen in a bottle. Mothers can easily be instructed to bring a recently wet diaper from home at least once in three visits. Ferric chloride test solutions can be kept active indefinitely in polyethylene squeeze bottles stored in the dark; the reagent is simple, cheap, and easily available.

BLOOD LEVELS IMPORTANT

Blood tests for phenylalanine levels are extremely important to confirm positive urinary findings before instituting dietary treatment. An interesting case report[7] describes a three-year-old blond child who was suspected of having phenylpyruvic oligophrenia on the basis of speech retardation and a positive ferric chloride urine test. Her blood phenylalanine level, however, was normal. Chromatographic investigation showed that both the patient and her clinically normal four-year-old sister had persistently elevated blood histidine levels and excreted large amounts of histidine in the urine. The fasting plasma histidine was six to eight times the normal, and each excreted about 10 times as much histidine as expected for the age. The parents did not show the same anomaly. It was suggested by the authors that these children have a hitherto undescribed inborn error in histidine metabolism. The complexities of amino acid metabolism clearly demand that the discovery of abnormal urinary ferric chloride reactions be followed in every case by adequate blood amino acid analyses—as much for furthering the general knowledge of abnormal protein metabolism as for indicating specific treatment.

Blood phenylalanine levels are important to identify affected siblings of known phenylketonuric oligophrenics, in which case the blood is drawn from the new infant at the age of one week.

Since the kidney threshold for excretion of phenylpyruvic acid does not accurately reflect elevated serum phenylalanine levels, frequent blood determinations must be made to assess the effect of dietary treatment of the phenylketonuric patient.[8]

In our case, a careful study of blood phenylalanine levels among the retarded and epileptic relatives might be rewarding, since kinetic disorders often accompany borderline mental deficiency in phenylketonuria. Since this was impractical, several urine specimens from the retarded and epileptic relatives were tested for phenylpyruvic acid; all were negative on repeated samples, with the subjects on normal diets. Although it is known that "loading" borderline cases with l-phenylalanine orally is a useful diagnostic measure and that it might be possible to control the seizures of epileptic family members by limiting phenylalanine intake, neither of these interesting possibilities has been attempted here.

A reeent directive published by the Hawaii Department of Health outlines a plan for screening for phenylketonuria all young infants attending Maternal and Child Health Clinics. This excellent program will utilize presently operating facilities and personnel. By the use of "Phenistix" (a modification of the ferric chloride test method) all infants attending well-baby clinics will routinely be screened the second and third month of age for defective phenylalanine metabolism.

It is hoped that the occurrence of this case of preventable mental retardation in a local child will stimulate cooperation with the Health Department's screening plan, and that a similar program will be undertaken by all physicians caring for infants outside organized well-baby clinics.

SUMMARY

A case study of phenylpyruvic oligophrenia is presented, together with the probable mechanism of the metabolic defect, and its damage to developing neural tissues. Treatment is briefly discussed, and the importance of the public health aspect of the disease is stressed. A standardized case-finding program is outlined, which will operate within the present Maternal and Child Health Well Baby Clinic program. Supplemental screening by private physicians of infants not attending Well Baby Clinics is urged. ●

Appreciation is acknowledged to the following persons who were of assistance in the study of this patient:

Dr. Mildred C. Mendenhall, Ph.D., Clinical Psychologist, Hawaii Mental Health Service

Mrs. Margaret Miller, Public Health Nursing Supervisor, Hawaii County

Mrs. Marian Shunk, Kohala District Public Health Nurse

Mrs. Louise Murakami, Medical Social Worker, Division of Mental Retardation, Hawaii State Department of Health

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Radiolucent gas in the heart and larger vessels is certain radiographic evidence of fetal death.

Gas Formation in Fetal Circulation As Evidence of Fetal Death

GEORGE BRACHER, M.D.,* *Hilo*

• *While the most common and most reliable sign of fetal death is still overlapping of the skull bones, the finding of air in the fetal circulation should be carefully looked for. When this sign is present, fetal death is certain.*

AS EARLY AS 1921, x-ray examination was advocated as an accurate method of determining fetal death. At that time Horner[1] and Spalding[2] first described the overlapping of skull bones with asymmetry of the skull as evidence of fetal death.

More recently other signs have been described: disproportion between fetal size and estimated fetal age; absence of growth in fetus; collapse of spine; and collapse of thoracic cage.

Roberts, in 1944, described the finding of gas in the fetal circulation as an indication of intrauterine fetal death.[3] His report was based on a proven case, the first described in the literature. No further cases were reported for five years, but since that time occasional reports have appeared. Ross,[4] in 1958, brought the total reported cases to 56. Bennett, in 1960, added another case and reviewed the literature,[5] bringing the total cases reported to at least 70. No one has successfully explained the origin of the gas, but it is thought to be nitrogen.

The following case was seen at Hilo Memorial Hospital:

A 22-year-old para 1, gravida 2, was admitted to the Hilo Hospital on June 18, 1961, with the following history:

She had had an uneventful pregnancy and had felt usual fetal movement until just prior to admission. She was last examined in her referring doctor's office on June 13, and at that time the fetal heart tones were well heard. Spontaneous rupture of the membranes occurred on June 16. She continued to feel fetal movement, and developed some uterine contractions on June 17, but after the onset of these contractions she no longer felt movement. On June 18, about 36 hours after she had last felt life, the patient presented herself at her doctor's office, where careful physical examination failed to find evidence of fetal heart sounds or of fetal movement.

The patient was admitted to the hospital, where x-ray examination was done on June 19. A pregnant uterus of term gestation was found. There was beginning overlapping of the skull bones and in the lateral projection free air could be identified in the fetal heart (Fig. 1). The diagnosis of probable dead fetus was made.



FIG. 1.—*Prenatal film showing gas in fetal heart. (At tip of arrow).*

* Radiologist, Hilo Memorial Hospital.
Received for publication October 20, 1961.



FIG. 2.—*Stillborn infant. Film made within one hour of birth. Gas shadows in heart and abdominal vessels.*

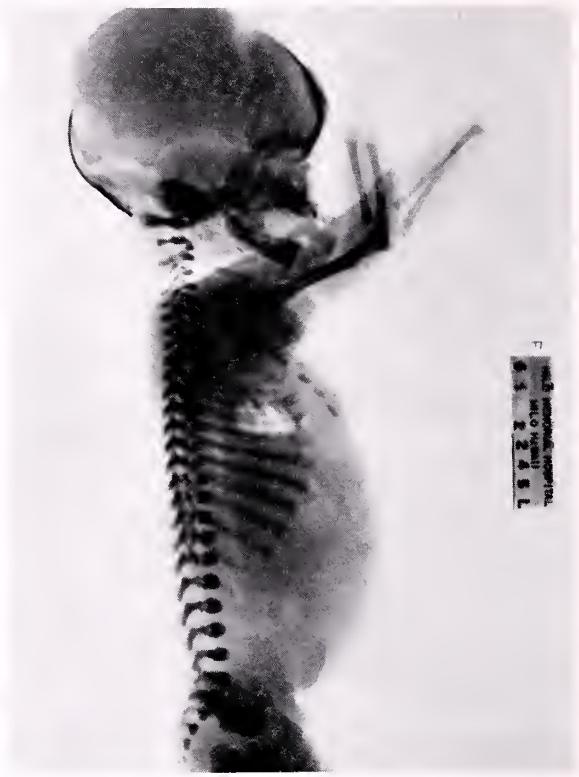


FIG. 3.—*Lateral view of stillborn showing gas in heart and aorta as well as abdominal vessels.*

The patient was stimulated into labor. After an uneventful eight-hour labor she delivered a stillborn fetus, full-term, without obvious abnormality other than mild maceration. There was a knot in the umbilical cord.

Films of the fetus were made immediately upon delivery. The fetal circulation and the chambers of the heart could be outlined on both the AP and lateral films. (See Figs. 2 and 3). The peripheral circulation could be traced into the upper extremity and into the skull.

Intracardiac blood samples were obtained for culture but no growth was obtained after a one-week incubation.

After this striking example of gas in the fetal circulation, all of the cases of stillbirth since 1955, occurring in the hospital, were reviewed. In those cases where maternal x-rays had been obtained prior to delivery, the x-ray films were restudied. Three additional cases were found showing recognizable gas in the fetal circulation and several more showed equivocal gas shadows.

Apparently this is a much more common sign of fetal death than has been thought and a more careful search for these gas shadows must be made in cases of suspected fetal death. In the eases at this hospital the gas is best seen in lateral films taken for soft tissue. ●

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Infant behavior is being studied at Kapiolani Maternity Hospital

Infant Research

DAVID H. CROWELL, Ph.D.,† *Honolulu*

• *Research in the United States relative to the neonatal and infant period of human development is inadequate in amount and poor in quality; the status of research for the same developmental period in Russia is more advanced. A Newborn Psychological Research Laboratory, established at the Kapiolani Maternity and Gynecological Hospital as an adjunctive facility of the University of Hawaii, may improve matters materially here in Hawaii.*

AFTER SURVEYING professional publications relating to children, Barker[1] in 1961 concluded that there was not only a scarcity of skilled child behavior specialists in the American scientific world, but also a deplorable lack of vigor as attested by low publication output, inferior quality of work, and scarcity of resources for research. The situation seemed further compounded by an increase in "programmatic, didactic, and speculative writing" at a time of increased demand by professional people for scientific information about children.

Directly to the point was Barker's observation that fetal, neonatal, and infant investigations were virtually nonexistent in the current picture. Brackbill[2] too has observed that the most striking gap in American experimental research with children is the developmental period from infancy to early childhood.

Offsetting this somewhat dismal picture, the ensuing decade has witnessed, for example, the recent sponsorship of a handbook "to accelerate the rate and raise the caliber of empirical investigations of growth and development" in children by the National Academy of Sciences National Research Council[3]; successive issues of *Research Relating to Children,*[4] describing projects as well as reflecting private and Federal financial support; and new projects to stimulate research training supported by the National Institutes of Health.

These developments may be only reflective of a growing national concern about research training and support, as witnessed by the report to the Committee on Appropriations of the 86th Congress.[5] On the other hand, it is heartening to know that some concern was evident before Sputnik accelerated basic scientific training and research in the United States.

RESEARCH IN RUSSIA

Publications in the area of child behavior, now broadly defined to include basic physiology as well as neurology and psychology, might be taken as an index of activity. A review of *Index Medicus, Psychological Abstracts,* or *Index Medicus New Series* and its predecessor, the *Current List of Medical Literature,* suggests that infants and children loom large as subjects for study in Russia.

Brackbill,[5] following a trip to the USSR, made the following points: (1) the outstanding feature of Soviet research is the sheer quantity of investigations dealing with children, based upon the assumption that the animal whose behavior merits priority is the human, and here infants and children are foremost; (2) though infant research is neglected in the United States, such is not the case in the Soviet Union, and further that instruments and facilities exist to promote such research (". . . Scheovanov's four experimental rooms contain more remarkable child research equipment than it has so far been my privilege to see"); and (3) interdisciplinary research is of the highest order, with problem formulation and research activity being carried on by physiologists, physicians, and biologists, in institutes of physiology, pediatrics, gynecology and obstetrics, and evolutionary physiology. It is even more striking that 53 years' worth of infant research has been accumulated and there exist immediate plans for expansion in this area.

Condensed version of lecture before physicians of Kapiolani Maternity and Gynecological Hospital on August 20, 1961. Research reported herein is supported by Grant M-3387, United States Public Health and the Graduate School, University of Hawaii.

† Director, Newborn Psychological Research Laboratory.

Received for publication November 30, 1961.

Of more immediate interest, but certainly corollary to the concern for basic investigations on infants, is the development of the Newborn Psychological Research Laboratory, formally established by the Medical Executive Board of Kapiolani Maternity and Gynecological Hospital in 1959. Their approval was unquestionably instrumental in securing the present financial support from the National Institutes of Health.

All laboratory procedures are carried on within the framework of hospital regulations. Participation by patients requires a signed permission statement from them, countersigned by the attending physician.

The basic current project of the Laboratory deals with infant responsiveness. Underlying this project is the hypothesis that behavioral responsiveness in clinically normal neonates and infants is a function of motivational properties derived from indices of central nervous system activities (activation level). In spite of indeterminate influences, such as undefined genetic factors, maternal prenatal activity and nutrition, maturity of the organism, and the concomitants and consequences of intra-natal conditions, it is assumed that continua of detectable individual differences do exist for both behavioral responsiveness and the derived central nervous system measures.

At the moment, activation level is secured from a continuous recording of basal plantar electrical resistance. Behavioral responsiveness is defined in terms of sensory-motor responses, threshold levels, simple classical defense eonditioned reflex learning, and gross neonatal motor activity. To date considerable time has been spent in refining measures and securing responses free from artifact.

At best, one can conjecture that apart from concentration on an area devoid of research, the project may stimulate current psychophysiological theorizing; accelerate the development of techniques in support of laboratory studies; develop studies on sensory-motor alertness; improve evaluation of developmental status, and coneeivably originate techniques for diagnosis. •

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In the next issue:

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Proceedings of the
House of Delegates



The Presidents' Page



I have offered the major portion of my Presidents' Page to your new President. However, I eannot leave without expressing my sincerest thanks to all my officers and committee men for their cooperation and loyal support during the past year.

I would also like to make one last statement. In my presidential address I censured those who opposed HMSA blindly without reservation. I am not unmindful of the deficiencies of HMSA and I appreciate that many times they have not taken a realistic attitude in approaching either the doctors' problems or those of the patients, and were apparently blinded by their desire to keep premium levels down. I believe that the quality of care given and the completeness of the coverage provided are more important to the subscriber than the eost of the premium. This is borne out by the fact that, regardless of HMSA's fears, their growth continued steadily despite the advent of Kaiser's plan. HMSA must realizc the need for these changes but they can only be aceomplished by mutual, completely honest negotiations, not by acrimony.

Mahalo.





This Presidents' Page starts a new year with a new administration. It means that the administrative activities of the Hawaii Medical Association will change only as is determined by personalities and viewpoints and not as to the long-term policies and ambitions of the Hawaii Medical Association. These goals which we have discussed and developed have been composed as a result of the revolution in society and a changed philosophical outlook on the part of the peoples of the world. A revolution is occurring and we are in the midst of it. We must continue to be flexible and alert so that our interests and the interests of our patients are protected and so that the progress of medicine can continue. It is in the United States that the coneept and practice of free medicine prevail but government interference remains. We are still the captains of our destiny. To remain in control of our destiny, we must be firmly united in our preeepts and in our actions. Constructive criticism by all members of the Hawaii Medical Association will be welcomed. Destructive activities will be fought. As a united group, we will make our contribution to the unity and power of the American Medical Association. It is the American Medical Association that must be our representative in the Halls of Congress where the laws are made and where the greatest political pressure is being exerted. We recognize that this political pressure is exerted for one reason only, that reason is for political eontrol and power, and not as is falsely put forth to bring medical care to the aged this time.

The people of the United States must be free to choose the kind of medical care which they want, to choose their doctor, and to choose how he or she, individually, will pay for that medical care. To this end we will devote our time and energy.



HAWAII MEDICAL JOURNAL

Editorials

Balnei Granuloma in Hawaii

A singular, warty, often imperfectly annular, chronic infectious granuloma, usually of the knee, foot, hand, or elbow, enlarging slowly over a period of as long as 20 years, is a skin lesion long familiar to physicians in Hawaii, especially plantation physicians and dermatologists. Very rarely a solitary acid-fast bacillus has been found in a biopsy specimen, but repeated efforts to cultivate an organism from the tissue were always unsuccessful.

The histologic picture of the lesions was remarkably uniform: epidermal hyperplasia, often pseudoepitheliomatous; a dense focal infiltration of lymphocytes, epithelioid cells and a few plasma cells, without tubercle formation; and rare small abscesses or foci of necrosis. It was not difficult for clinician and pathologist to agree on a diagnosis of tuberculosis verrucosa cutis, and it was under this label that Harold Johnson[1] reported three typical cases in 1950, all treated successfully with intramuscular injections of streptomycin and potassium iodide orally.

In the following year Cleveland[2] reported from Vancouver four cases of skin granuloma, "possibly tuberculous," in which the infection seemed to have started in abrasions incurred in a chlorinated tidal salt-water swimming pool. He said that Williams (also of Vancouver) had also had four such cases, three of them from the same pool.

In the same year Linell and Norden[3] described a skin granuloma acquired in swimming pools from which they cultivated an acid-fast bacillus which looked like Mycobacterium tuberculosis but grew only at 30-33° C, not at 37°. In 1954 they published a definitive monograph[4] on it, naming it Mycobacterium balnei. The lesion has since been known as the "swimming pool granuloma."

The granuloma we see in Hawaii bears little resemblance to the reported cases of swimming pool granuloma, aside from its occurrence on projecting portions of the anatomy. It has not yet been observed to start in an abrasion acquired in a swimming pool—though reservoirs, irrigation ditches, and ocean water near the shore have been implicated. It rarely ulcerates. It does not tend to heal spontaneously (except in its center), whereas virtually all reported swimming pool granulomas have been of well under two years' duration, and most have healed in a few months. The epidermis covering it is not thin and atrophic; on the contrary, it is markedly hyperplastic, clinically warty in appearance. Histologically, epithelioid cells are far outnumbered by lymphocytes, unlike the great predominance of epithelioid cells seen in swimming pool granulomas; and epithelioid tubercles are very rarely encountered.

Nevertheless, Walker and his associates at Leahi Hospital in Honolulu have isolated M. balnei from tissue specimens in eight cases of nodular or verrucous granulomas of the skin occurring in lifetime residents of Hawaii. Their work is reported elsewhere in this issue.[5] The bacteriologic identification of the organism is sufficiently secure to outweigh the incompatible clinical and histologic criteria for diagnosis. One might postulate that a special strain of M. balnei, bacteriologically indistinguishable from the ordinary one but differing from it in pathogenicity, accounts for the different lesions produced. A recent bit of additional evidence, however, suggests that this may not be so.

Captain A. F. J. Sommer, Colonel Raymond M. Williams, and Major Adrian D. Mandel, M.C., U.S.A., have reported from the 34th General Hospital[6] two cases of a verrucous granuloma of the skin, one of the knee of 17 years' duration, the other present on the foot for four years. The latter began in an abrasion experienced in a reservoir. Both showed the characteristic clinical and histologic features described above for our Hawaii granuloma. M. balnei was isolated and positively identified in tissue from both cases. And both patients were young Japanese men, born and raised on the island of Maui, in Hawaii.

The point that makes a distinct strain of M. balnei unlikely is that one of the authors inoculated himself with the cultured organism, and developed

a typical "swimming pool" granuloma, which ulcerated superficially, crusted, and healed spontaneously in a few weeks.

The chief importance of these observations is well expressed by John M. Knox of Houston, who reported a similar case[7] last fall. This patient had a warty granuloma of the elbow from which another "atypical acid-fast" bacillus, a scotochromogen (pigmented even in the dark; M. balnei is a photochromogen, darkening only after exposure to light) of Runyon Group II, was grown by reducing the incubator temperature from 37° to 25° after the first few days. Said Knox:

> . . . the possibility must be considered that some of the cases previously diagnosed as swimming pool granuloma and tuberculosis verrucosa cutis, and possibly even other types of cutaneous tuberculosis, in reality were not tuberculosis at all but were actually "atypical" mycobacterial granulomas. This possibility should alert physicians so that they may obtain proper bacteriological studies in every instance. . . .

The observations have additional importance with relation to treatment. M. balnei is generally sensitive to streptomycin, but it is not susceptible to isoniazid or to PAS. Some of the other "atypical" acid-fast bacilli are not susceptible to streptomycin, however. It may be that Johnson's use of potassium iodide as an adjuvant to therapy, which is certainly less hazardous than it might be if the lesions were actually tuberculous, will help to render sensitivity tests unnecessary. These should be done, however, in cases due to other organisms than M. balnei.

HARRY L. ARNOLD, JR., M.D.

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Birth Defects

Eight skeptics left Honolulu in late January to attend the First Inter-American Conference on Congenital Defects in Los Angeles, California. 500 scientists representing the fields of physics, biochemistry, genetics, embryology, cytology, and every field of medicine answered the call of the National Foundation to share their fragmentary knowledge on the causes and prevention of birth defects.

Skepticism often stems from lack of knowledge, and the skeptics were privileged to learn from the laboratory and clinical giants that the National Foundation is not raising money to exist, but is continuing its existence to raise money for an all-out attack that has the potential for preventing a host of diseases that we now refer to as "diseases of unknown etiology." The harelip which, incidentally, was scarcely mentioned, is but one of 600 anomalies now recognized as "birth defects." To list but a few: Cooley's anemia, fibrocystic disease of the pancreas, thalassemia, galactosemia, phenylketonuria, porphyria, and mental deficiency in many forms may well be reduced to a derangement in the structure of complex molecules, attributable to the absence or environmental inhibition of the enzyme system responsible for a normal linkage of the components of the macromolecule.

An example of this is seen in the substitution of a single amino-acid in the chain of 189 amino-acids, resulting in an abnormally shaped hemoglobin molecule which distorts the shape of the erythrocyte and causes trapping of the erythrocytes in the venous sinusoids of the spleen.

It is exceedingly appropriate that the theme of the annual meeting of the Hawaii Medical Association in May was "Inborn Errors," and we should welcome the National Foundation's support and encourage support of the March of Dimes which permits voluntary participation in research, education, and services on behalf of individuals and families with diseases in these categories. In the task ahead, the National Foundation's work is not to duplicate services that are now functioning in our state for the handicapped child, but to support research and services that will prevent handicaps from birth defects. •

R. FREDERICK SHEPARD, M.D.
Medical Director
Rehabilitation Center of Hawaii

In Memoriam – Doctors of Hawaii

This is the thirty-eighth installment of In Memoriam—Doctors of Hawaii.

Lawrence Leslie Patterson

Lawrence Leslie Patterson was born July 27, 1885, at Marion, Iowa. He was the son of Henry Schuyler and Emma Frances (Doran) Patterson.

His elementary education was received in the Iowa public schools and at the West Des Moines High School. His medical degree was granted by Denver and Gross Medical College in 1909. Dr. Patterson served his internship at St. Anthony's Hospital in Denver.



DR. PATTERSON

Following his internship, Dr. Patterson came to Honolulu in July, 1910, to relieve Dr. C. R. McLean, physician at Ewa plantation, for six months.

In 1911 the doctor joined the staff of the Honolulu Plantation Hospital. He held this position until he resigned in 1916 to become chief of the Territorial Anti-Tuberculosis Bureau and Medical Inspector of Schools.

During World War I Dr. Patterson served as a major in the U. S. Army Medical Corps at Schofield Barracks for 16 months.

At the termination of his military service in August, 1919, Dr. Patterson accepted a position as physician for the Kilauea Sugar Company and government physician for the Hanalei district of Kauai. Later he established a private practice in Kapaa, Kauai.

On December 21, 1918, Dr. Patterson married Mabel L. Larsen. Two sons, Richard L. and Lawrence L., Jr., were born to the couple. After the death of his first wife, Dr. Patterson married Ruth Yaeko Wakayama of Honolulu on April 23, 1927, and they became parents of a daughter, Ruth Yaeko.

For many years Dr. Patterson took an active part in politics. He was elected to the Territorial House of Representatives for the 1927-1928 term. He also served on the Kauai County Board of Supervisors in 1945 and 1946 and on the Public Utilities Commission.

Dr. Patterson died December 15, 1953, at Wailua, Kauai, at the age of 68.

He was a member of the Kauai County Medical Society, the Hawaii Medical Association, Kauai Chamber of Commerce, American Legion Kauai Post Number 2, and was a Mason and a Shriner.

Gilbert A. Foote

Dr. Gilbert A. Foote was thirty-three when he arrived in Honolulu July 26, 1889, aboard the "Australia." Nothing is known about the doctor prior to his coming to the Islands other than the fact that he had joined the California Medical Society in April, 1888. On his arrival, he was appointed a government physician for the Kau district of Hawaii.

By April, 1891, all was not well between the doctor and the Board of Health. The *Advertiser* carried the story that the Board had asked for his resignation and that he had refused to comply. In July of that same year Dr. Foote sent in his own resignation, giving less than the required one month's notice. An article from Kau reports that the residents of Waiohinu and vicinity gave the doctor a farewell party and adds that the friends of Dr. Foote "deeply regret his departure, as their relations with him have always been of the pleasantest, and they have taken this opportunity of bearing witness to their high appreciation of him as a man and as an officer of the government." Whatever his relations with the Board of Health, he seemed to have won the affection and respect of his patients.

After leaving Kau, Dr. Foote came to Honolulu to become associated with Dr. John Brodie. Early in January, 1892, when Dr. Brodie left to settle in San Francisco, Dr. Foote continued the practice with his office at the corner of Beretania and Miller Streets. In October, 1892, Dr. Foote left for Hong Kong and did not return until the following March when he again took up his practice in Honolulu.

By September, 1893, the doctor was reported as being seriously ill, and on March 3, 1894, he was carried aboard the "Australia" to return to California. Before his illness he had weighed 240 pounds but weighed only 90 when he boarded the ship, and his friends feared that he would not survive the trip. However, Dr. Foote lived until May 29, 1894, when the *Advertiser* reported his death in "a small California town."

While in Honolulu, he was a Master Mason of Hawaiian Lodge No. 21, F. & A. M. •

HAWAII MEDICAL JOURNAL

This Is What Was New!

• A Boston expert emphasizes that **medical electricity** is both a science and an art, and that the mode of applying electricity to the human body or limbs has much to do with the results. By "intelligent discrimination in selecting the cases, the stage of the affliction, the form of electricity, that is, the electric machine, (the Galvanic Battery or the method of its application uniform success can be anticipated. . . . Difficult amenorrhoea and Dismenorrhoea [*sic*] respond very well to the negative electrode being placed in the vagina before the current is turned on. Obstinate constipation is relieved by similar placement of the electrode in the rectum." (Guide for Using Medical Batteries, A. C. Garrott, M.D., Fellow of the Mass. Med. Soc. & member of the A.M.A., Philadelphia, Lindsay & Blakiston, 1867.)

• The highly-regarded surgeon, Dr. Samuel Gross, has observed that "ill effects of **leeching** are more apt to occur when leeches are sickly or when they are applied to patients of nervous or irritable temperaments. He finds the best leeches are Swiss, German, French, and Spanish. These generally take hold with great avidity and draw from half an ounce to six drachms of blood. The American leeches, although much larger than the European, bite reluctantly and suck sluggishly." (System of Surgery, S. D. Gross, M.D., Philadelphia, H. C. Lea, 1866.)

• Dr. Williams, who referred his patient to Dr. Garrod for a blood uric acid, had this to say about diabetes. **"Diabetes** is one of those diseases which we may fairly hope to cure when our knowledge of animal chemistry shall be more advanced. The fact that febrile and inflammatory diseases suspend it for a time, that is, cause the sugar to disappear from the urine, is a proof that the morbid production of sugar is not necessarily permanent and that we may therefore anticipate that **it may be prevented** by artificial means." [Banting and Best had somewhat similar ideas over half a century later.] (Principles of Medicine, Revised London Ed., Charles J. B. Williams, M.D., Philadelphia, H. C. Lea, 1866.)

• Inflammation of the caecum or its **appendix** is remedied, when it can be remedied, by leeching, warm fomentations, mercurial inunctions, opiates, and in case of suppuration, **surgical aid** to produce an early exit of pus. (Medical Diagnoses, J. M. DaCosta, M.D., Philadelphia, J. B. Lippincott Co., 1866.)

• **Gout** has recently been proved to be associated with **an excess of lithic (uric) acid** in the blood. "Dr. Garrod has succeeded in detecting lithic acid in the blood of a gouty patient at the University of College Hospital in London."

• Austin Flint is recommending a **low-fat diet** in the treatment of **coronary arteriosclerosis.** "Therapeutically," he says, "it would seem to be an object to diminish the amount of oil in the blood in cases of obesity. The latter is also an object in cases of fatty degeneration of the heart and arteries, if it be true, as is highly probable, that this structural change is either dependent upon or favored by an excess of oil in the blood. The diminution of oil in the blood is effected by restricting the diet to nitrogenous substances [protein], avoiding butter, fat, meats, and sugar, and limiting the amount of farinaceous food."

• Dr. Flint has also recently observed a family that illustrates the hereditary nature of tuberculosis. In the family personally observed by him, the mother and her seven children died of tuberculosis of the pulmonary variety. Dr. Guy of London reported the curious fact that people who live in big rooms were less likely to have pulmonary tuberculosis than people who live in small rooms. However, the production of tuberculous lesions in certain inferior animals by inoculating them with matter obtained from tuberculous products in man by the French surgeon Dr. Villemin naturally leads to the inquiry as to whether **pulmonary tuberculosis** may not some times be caused in man by the inhalation of a **virus contained in the breath of tuberculous patients.** (Principles & Practice of Medicine, Austin Flint, M.D., Philadelphia, H. C. Lea, 1873.)

• The United States is faced with **a great physician shortage.** Twenty-three hundred new physicians are required in the United States every year. To meet this, there are only 1,400 graduates from medical schools in the United States and about 300 foreigners, leaving **a deficit of 600 physicians a year.** In that the average life of a physician is not over 30 years, approximately 1,000 are lost every year by death and 300 are lost to the profession by changing to some other line of work, it is obvious that this large country of over 20 million inhabitants will soon be in for a very severe physician shortage. (*Lancet* [Jan.] 1856, N. Y. Ed.) •

F. I. Gilbert, Jr., M.D.

HAWAII'S OWN PREPAID MEDICAL SERVICE PLAN



GEORGE M. EWING, M.D.
Secretary, Hawaii Medical Service Association

I have served as Secretary of the Hawaii Medical Service Association for the past two years.

Through my association with this community service association, I have gained more understanding of the role of a prepaid medical service plan in a community.

Here, in Hawaii, we have undoubtedly one of the finest prepaid medical service plans in the nation.

It is amazing when one realizes that HMSA was conceived only twenty-four years ago with a membership of 670, and today has an active membership of over a quarter of a million. Responsible for this growth has been HMSA's service features and its basic concept of offering the best possible medical plan at the least possible cost to the residents of Hawaii, plus continued cooperation and assistance by the medical profession.

Prepaid medical service plans like HMSA are of the greatest importance in America's economy today in allowing "free choice" of physician and hospital and serving as one of the most effective weapons against socialized medicine.

HMSA®

"HMSA NO KA OI"

HAWAII MEDICAL SERVICE ASSOCIATION

(Advertisement)

HAWAII MEDICAL JOURNAL

Brief Reports on Poisoning

Poison Case Report No. 3—Lead Poisoning:

CASE 1: This three-year-old girl was admitted in December, 1961, to an urban hospital because of recurrent vomiting of about five days duration. There were also some irritability, intermittent abdominal pain, and constipation. A slight fever was noted about three days prior to admission. A history of lead ingestion from old paint chippings on the walls was obtained. She was undernourished, slightly dehydrated, and anemic. She was slower in mental development than her siblings and had a perverted appetite (pica).

On admission, her hemoglobin was 8.3 gm %, and the white blood cell count was 13,300. Basophilic stippling was present and the red cells were hypochromic and microcytic. Urine contained a trace of albumin and 3-plus acetone. The qualitative urinary coproporphyrin test was positive. The blood chemistries were as follows: Na, 127 mEq/l; K, 2.8 mEq/l; Cl, 102 mEq/l; CO_2, 14 mEq/l; Ca, 9.4 mg %; blood sugar, 120 mg %; BUN, 8 mg %, and cholesterol, 196 mg %. The blood lead was 20.1 mcg/10 gm blood (Normal—1-6); the urine lead, 403 mcg/100 ml. urine (Normal—1-10).

The skull x-ray was normal. The abdominal film revealed some opaque material in the rectum. The findings in the knees, hands, and wrists were classical for heavy metal poisoning. The bone age was considered in the 20-25% normal group.

Following correction of fluid electrolyte imbalances, the patient was treated with calcium disodium versenate (CaEDTA, calcium disodium ethylenediaminetetraacetic acid).

CASE 2: This 21-year-old man was admitted to an urban hospital in October, 1959, with the chief complaint of abdominal pain and vomiting for two days. The pain was colicky and intermittent. The patient complained of anorexia, headaches and dizziness. The bowel movements were regular. About two months prior to admission, he had noted a peculiar metallic taste in his mouth and felt an occasional abdominal cramp. He was employed at a lead foundry and handled battery casings. On examination, there was bluish pigmentation on the palate, tongue, gums, and buccal mucosa. The abdomen was slightly tender on palpation. The hemoglobin was 10.2 gm % and there was basophilic stippling of the red cells. Urinary coproporphyrins were present. The blood lead was 44 mcg/10 gm. The urine lead was 43 mcg/100 ml. The removal from further exposure to lead and supportive measures aided in his prompt recovery.

DISCUSSION

For the past five years, the Poison Control Center has recorded only three cases (two described above). The Center is aware of other sources for lead intoxication including lead on poorly-fired porcelains, lead in infant powders and face powders, lead sprays on fruits, and lead toys. However, no cases have resulted here due to these sources.

The onset of symptoms is insidious, usually following a long period of exposure to lead.

Central nervous system disturbances are seen in at least 40 percent of children with plumbism, whereas in adults, neuromuscular symptoms predominate. Vomiting and abdominal pain are common complaints. Other presenting signs and symptoms are anorexia, headaches, pallor, irritability, constipation, dizziness, and a metallic taste in the mouth.

Sometimes, a scout film of the abdomen may reveal radio-opaque material in the intestines. Long bone survey may reveal the typical lead lines at the growing ends of the shafts.

TREATMENT

The management of lead poisoning may vary with each case. The prime objective rests in the treatment of acute symptoms and the promotion of excretion of lead substances. The use of deleading treatments is not recommended in every case. In most industrial poisonings, the removal of the patient from the source results in clinical improvement. Some authorities advise that no deleading program should be instituted until the patient shows a clinical response to supportive measures. Rapid removal of lead from the body may reinitiate cerebral symptoms. Calcium versenate is contraindicated whenever lead is present in the intestines, since the drug may hasten absorption.

1. For lead colic, intravenous calcium gluconate (10 %) is given. This may be followed with an intramuscular dose. Antispasmodics such as atropine, morphine, and methadone may be used.
2. A simple saline carthartic is also administered.
3. Sedation should be given when necessary for convulsions.
4. Supportive alimentation is important. Dehydration and acidosis should be prevented or corrected cautiously.
5. Blood transfusion may be given for severe anemia.
6. If deleading procedures are needed, give calcium disodium versenate intravenously or subcutaneously by drip method. The dose recommended for children is 30-75 mg per kg of body weight; for adults 1.0 gm daily, for 3-5 days. Solutions of 0.25-0.5% prepared with 5% dextrose in distilled water are generally recommended, and treatments may be given in two divided doses.

   Sodium citrate (1-2 gms three times daily) may also be given.
7. If severe cerebral edema is suspected, evaluation by a neurosurgeon should be sought. ●

RICHARD K. B. HO, M.D., *Director*

1. Lead Conference-Chicago, Nov. 6-7, 1958. Ind. Med. & Surg. 28:93-162 (Mar.) 1959.
2. Von Oettingen, W. F., Poisoning, a Guide to Clinical Diagnosis and Treatment, ed. 2, W. B. Saunders Co., Phila., 1958, pp. 399-403.
3. Nelson, W. E., Textbook of Pediatrics, ed. 7, W. B. Saunders Co., Phila., 1959, pp. 1375-78.

HAWAII MEDICAL JOURNAL

County Society News

Honolulu

The February 6 meeting was attended by approximately 195 members. A film, "Life Story," was shown through the courtesy of the American Cancer Society and Dr. Doris Jasinski made some brief comments on it.

The main speaker of the evening, Mr. Donald Billam-Walker of the Better Business Bureau, spoke on recent cases of medical quackery in Honolulu.

Members were asked to pick up their AMA Speaker's Kit on Health Care of the Aged at the county offices. Dr. Pinkerton advised that a new committee to handle contracts is being formed on a state basis. The Public Utilities Commission reported that some of the tentative procedures requested by the HCMS ad hoc committee involved a man's eligibility would be followed.

Announcements were made relative to the mandatory attendance provisions of the bylaws, the forthcoming postgraduate series, fee negotiations on both the Veterans contract and the Bureau of Crippled Children's schedule.

The Medical Care Plans Committee advised that it had studied the matter of permitting a physician to charge his usual fee when the patient has double coverage. It decided that as far as HMSA is concerned when a physician signs an HMSA contract, he agrees to charge according to its fee schedule. Double coverage does not change this agreement as far as participating physicians are concerned.

Dr. Pinkerton spoke on the AMA proposal that county medical societies launch a series of newspaper advertisement which give out informational messages. He said this would be referred to the State PR Committee.

Dr. Hartwell discussed certain problems confronting the medical profession, especially as they relate to the HMSA.

Over 200 members attended the March 6 meeting. Another in the series of films produced for the American Cancer Society was shown entitled "Oral Cancer—The Problem of Early Diagnosis." Dr. James H. Shoemaker, vice-president of the Bank of Hawaii, presented a talk on the "Long Range Economic Outlook on Hawaii."

New members James G. Bennett, John R. Stephenson, and Louis Pang were welcomed into the Society.

Dr. Robert Wong presented the auditor's report for 1961 and reviewed some of the important items. It was voted to accept the report.

Dr. Hunter presented the Fee Adjustment Committee's recommendations on minor surgical and plastic surgery fees which will be submitted to HMSA for its consideration. It was voted to approve of these changes as circulated. It was also voted that a tray charge be set up with a unit value of 1.5.

Drs. Varian Sloan and Toru Nishigaya addressed the Society on matters relating to public relations and statistics involved in the King-Anderson type legislation.

Hawaii

A second meeting was held February 23 to meet with Mr. William McAuliffe of the AMA's Legal Department. Mr. McAuliffe gave an interesting discussion on the King-Anderson Bill and showed a film of Dr. Annis. He presented each member with a WHAM folder and urged all doctors and their wives to take an active interest in legislative matters.

Drs. George Bracher and Etta Wright Best were welcomed into the Society.

The regular March meeting was held on the 16th in order that the members of the HMA's Maternal and Infant Mortality Study Committee could be present. These members brought with them a visiting professor, Dr. Samuel Levine, who spoke on "Respiratory Distress Syndrome of the Newborn." In addition one maternal death study was presented by the chairman, Dr. George Goto.

Dr. Okumoto advised the Society that he had attended the annual HMA party for the Legislature, which he found quite interesting. He read a letter from Children's Hospital advising that information from the Poison Control Center is available on a 24-hour basis. The University of Hawaii, Hilo Campus, advised that books will be bought with the $500 the Society donated in memory of Dr. Kutsunai.

A motion was passed to purchase newspaper space expressing the Society's views on the King-Anderson Bill.

Kauai

A large portion of the February 6, 1962, meeting was devoted to a discussion of the medical care of the county pensioners. Hospital administrators, County board members, a representative of the Department of Social Services, and the Society's attorney were present at the meeting. No final decision was made.

Dr. Enright demonstrated the hypodermic injection gun.

On February 22 a special meeting was held to meet Mr. William McAuliffe from the Socio-Legal Department of the AMA.

The March 6 meeting was attended by nine members and three guests. Dr. J. A. Burden was present and spoke to the members.

The members voted to write letters to several service organizations to see if they might be interested in seeing the film made by Dr. Annis.

It was voted to waive the dues of Drs. Kuhns and Zandee. Plans were discussed for keeping Society records.

Dr. Matthew gave a short talk on the work that is being done at Queen's laboratory.

At the April 3 meeting Dr. David Tien was accepted as a new active member.

Maui

The first meeting of 1962 was held on February 20 at the Wailuku Hotel. Guests present were Drs. Wallis, McGovney, Graumann, and Mr. William McAuliffe, plus members of the Woman's Auxiliary. Prior to the business meeting, a film was shown featuring Dr. Edward Annis, who spoke on the King-Anderson Bill. After a talk by Mr. McAuliffe, the women adjourned to Dr. Haywood's home for a discussion of the WHAM program.

A letter was read from Mr. J. R. Veltmann of the HMSA concerning the recommendation that a hospital usage committee be set up to guard against over-utilization of hospital facilities. The motion was unanimously passed that the Society recommend to the hospital staff that such a usage committee be formed.

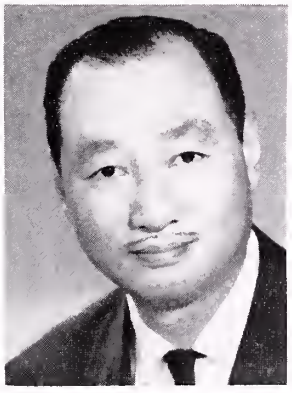
A motion was unanimously passed to pay the expenses of sending a Maui representative to the HMA meetings of a newly formed committee which will negotiate statewide contracts. Since a majority of the members were not present, the chair requested that a letter be sent out to each member, polling them on their feelings concerning this matter. ●

HAWAII MEDICAL JOURNAL

New Members



John R. Stephenson, M.D.
1000 Ward Avenue
Honolulu 13, Hawaii
Pediatrics
UCLA Medical School, 1956
Internship—UCLA Hospital
Residency—Kauikeolani Children's Hospital



David Tien, M.D.
Lihue, Kauai
General Surgeon
Christian Cheeloo University, 1943
Internship—Cheeloo Hospital
Residency—Cheeloo Hospital
Manitoba Hospital



James G. Bennett, M.D.
1697 Ala Moana Blvd.
Honolulu 15, Hawaii
Radiology
Harvard Medical School, 1939
Internship—Hitchcock Hospital
Residency—Hitchcock Hospital
Mayo Foundation



George Bracher, M.D.
Hilo Hospital
Hilo, Hawaii
Radiology
University of Oregon, 1934
Internship—St. Vincent's Hospital, Portland
Residency—University of Oregon Medical School
University of Chicago Medical School



Etta Wright Best, M.D.
Hilo Hospital
Hilo, Hawaii
Pathology
University of Louisville, 1949
Internship—The Queen's Hospital
Residency—The Queen's Hospital
Mayo Clinic

HAWAII MEDICAL JOURNAL

Notes and News

New Affiliations

Dr. Teruo Yoshina has "pulled up stakes" and set up practice down the peninsula in the Bay Area (California). Good Luck, Tom!

Dr. Mitsuo Tottori (pediatrics) has taken Dr. Yoshina's offices at 1024 Piikoi St.

Dr. Carl M. Mirikitani (ENT) is now practicing at the Medical Arts Building. Ditto **Dr. Clifford K. Mirikitani** (surgery).

Dr. Henry A. Manayan is now associated with **Dr. Corazon Manayan** at 311 So. Vineyard St.

Dr. Shigeru Horio is now affiliated with the boys on Ala Moana Blvd.

Dr. Rowlin L. Lichter is one of the newer ones locating at 1441 Kapiolani Blvd. Ditto **Dr. Maurice L. Silver.**

Dr. Robert K. Mookini, Jr., is now in the new Pali Medical Building.

Congratulations to . . .

Dr. William Walsh, for his "ace" on the 139-yard 16th hole at the Oahu Country Club. Nice going, Bill!

Dr. William N. Bergin of Hilo, who was named president of the Royal State Insurance Company.

Dr. Pete T. Okumoto, who was reappointed and confirmed as a regent of the University of Hawaii, and who received the Robins Community Service Award in May at our annual meeting.

Dr. Varian Sloan, who was elected to the Board of Governors of the American Academy of General Practice. He has the distinction of being the first member from Hawaii.

Travel News

Dr. Pete T. Okumoto recently was mainland-bound to interview applicants for president's post at the University of Hawaii.

Recent conventioners in Las Vegas for the AAGP included **Drs. Varian Sloan, John Felix,** and **Walter Ozawa.**

Dr. George Ewing was seen in the company of HMSA executives at Colorado Springs attending the National Blue Shield Conference on the problems of insuring the aged.

Information, Please

The Department of Health would like to have information on those cases of E. Histolytica diagnosed from sigmoidoscopy. If you have any experience in this, contact **Dr. Ira Hirschy.**

Names in the News

Dr. Pershing S. Lo was the center of much attention recently when a potentially dangerous mental patient, who had threatened him previously with a gun, escaped from the State Hospital. **Dr. William J. T. Cody,** as Medical Director, was also mentioned and had to explain the escape.

Suggestion has been made that **Dr. Morton Berk** "retire" from practicing and go "Bohemian." His oil, "Whitewood," sold for $1,700 at a recent Heart Fund auction. Prominently mentioned at the same affair were **Drs. Fred Gilbert** and **Tom Fujiwara,** who purchased Lloyd Sexton's "Quiet Morning."

Rep. Dorothy Devereux, wife of **Dr. John Devereux,** remained in serious but improving condition at Queen's following injuries received in a fall at Iolani Palace. Her attending physician received several "plugs."

Dr. John Felix reported theft of checks and cash when his office was burglarized.

Dr. L. E. Eckles, Kauai, is now medical director of the Waimano Training School and Home.

Dr. John F. Burnett suffered $8000 damages to his Foster Village home as the result of a fire.

Dr. Joseph P. Cochran, former medical missionary, is the interim physician for the Hana district. He replaced **Dr. H. Anderson.**

Lt. Col. W. E. Mayer, former Hilo psychiatrist and guest speaker at the memorable last HMA annual meeting in Hilo, was recently a visitor in Hawaii.

Sometimes it's risky business to be on the governing board of a hospital! **Drs. Joseph Strode** and **Harry Arnold, Jr.,** were named defendants in a suit by a physician who claimed he had been denied permission to practice at Queen's and other hospitals.

Dr. Steele F. Stewart (retired) was featured in the *Advertiser* for his activities as a consultant for the International Travel Agency. His son, **Dr. Steele F. Stewart, Jr.,** now an OB resident at Johns Hopkins, was licensed here in May.

Dr. Gordon Liu has been named medical director of the St. Francis Hospital's new Home Care Center.

Dr. Scott Brainard and The Queen's Hospital open heart surgical team were the recipients of well deserved but infrequent publicity.

Dr. Ralph B. Cloward showed much talent at the recent "Fashioning Hats for the Ladies," promoting the coming of Easter.

Drs. Richard Omura and **C. F. Chang** were quoted in the "Inquiring Reporter" column. Appropriately the question was "Do you favor socialized medicine?" (They didn't.)

Names appearing on the Academy Board of Chaminade College include **Drs. William Bergin, John Chalmers, John Felix, Cesar de Jesus,** and **A. L. Vasconcellos.** Dr. De Jesus is the sole physician on the Auxiliary Board of the East-West Center.

The HCMS Woman's Auxiliary's "Spring Tonic" for the AMEF was the subject of great coverage in the local society columns. Doctors mentioned were too many to enumerate.

Dr. John F. Chalmers, who twice had his car stolen, ingeniously set a trap and brought about the apprehension of the thief.

Dr. E. Wonsik You is much in the picture in the development of a resort hotel on Guam.

continued page 460

HAWAII MEDICAL JOURNAL

Book Reviews

Afraid of What?
Dear Little Mumps Child
Dentists' Tools
Doctors' Tools
How We Hear
Kalle
Karen Gets a Fever
Lefty
Michael Gets the Measles
Penny the Medicine Maker
Peter Gets the Chickenpox
Red Man, White Man, African Chief
Twins
Warts
Why Glasses

By Marguerite R. Lerner, M.D., A Series of 15 Books, $2.75 each, Medical Books for Children, 1961.

THIS IS a series of books for children of pre-school and early elementary age distributed by the Creative Education Society in Honolulu. There are several of them, covering such topics as measles, mumps, chickenpox, fever, penicillin, etc. They are well and authoritatively written by Marguerite R. Lerner, M.D., with a brief appendix containing further information for parents. There are some, *How We Hear, Why Glasses?*, and possibly *Twins*, which may be a little deep for the child to whom the others are written, but which nevertheless can be recommended for the older child.

JOHN R. STEPHENSON, M.D.

Cancer Chemotherapy Vols. 1 and 2

Prepared by The Staff of the University of Texas M. D. Anderson Hospital and Tumor Institute Texas Medical Center, Houston, Texas, under the direction of R. Lee Clark, Jr., M.D., D.Sc. (Hon.), 253 pp., $10.50, Charles C. Thomas, 1961.

THIS SUCCINCT and lucid book tells how to treat various malignancies with drugs. Discussions of some substances are necessarily brief and many of the techniques used in administration of the drugs are based on the experiences of the M. D. Anderson Hospital. But an extensive bibliography has been provided.

The latter sections, being clinical, are a bit more rewarding to the practitioner than the earlier biochemical portions. For all, this is a good volume for all who are interested in chemotherapy.

WALTER Y. M. CHANG, M.D.

★The Management of Acute Poisoning

By Gordon Cumming, B.Sc., Ph.D., M.B., Ch.B., A.R.I.C., 128 pp., $3.00, Charles C. Thomas, 1961.

THE AUTHOR presents a concise, philosophical guide to the management of acute poisoning. The physician learns to treat the patient as a whole individual and to recognize and manage the physiological effects of poisons as well as the psychological, social, and personal difficulties culminating in the ingestion of toxic materials.

The book is not intended to be a reference in toxicology and can therefore be read easily in a matter of hours without unnecessary exposure to monotonous details and data which could be found elsewhere.

RICHARD K. B. HO, M.D.

★Ciba Foundation Study Group No. 8 Problems of Pulmonary Circulation

Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A., 96 pp., $2.50, Little, Brown and Company, 1961.

THE PROBLEMS of pulmonary circulation are reviewed by a study group composed of outstanding pulmonary physiologists of the world under the chairmanship of Dr. A. Cournand. Radiologic, clinical, hemodynamic, and pathologic studies are reviewed, correlated, and brought to date in this compact book.

The subjects are covered with almost teletype brevity. The references are historical, lengthy, and current, and the discussions following each subject are provocative.

The experimental and clinical physiologists engage in interplay of hypotheses and experiments, triggering discussions. Investigations bearing on information contained herein are proposed.

ANNA MARIA BRAULT, M.D.

★The Cervix Uteri

By C. Frederic Fluhmann, B.A., M.D., C.M., 556 pp., $14.00, W. B. Saunders Company, 1961.

THE SINGLE most significant contribution Dr. Fluhmann makes in this book is his description of the clefts and tunnels of the glandular structure of the cervical epithelium. In this painstaking monumental work, the author clearly points out the fact that the cervical glands are not tubular and racemose in type by doing serial sections of the entire cervix.

The sections on diagnostic procedures and congenital anomalies and traumatic and functional disorders are quite complete and leave little to be desired. For completeness' sake the infectious granulomas, fungus, parasitic, and unclassified inflammatious are included in the section on inflammatory diseases. Since the cervix plays a minor role in these diseases, the descriptions are sketchy and perhaps best left out. The sections on new growths and pregnancy are exceptionally lucid.

This book should be read by all physicians interested in the specialty of obstetrics and gynecology.

GEORGE GOTO, M.D.

★Pathology, 4th Ed.

By W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P. (Editor) 1389 pp., $18.00, The C. V. Mosby Co. 1961.

I REMEMBER reading once where a female medical student routed an ill-meaning intruder by throwing a medical textbook. After carrying this one around a few times, I would rank this text among the medical student's larger textbooks. This brings up the age-old question. Is it too large and is there too much detail for medical students? If not, is it good to engender and foster the idea that all one needs to practice medicine is one outstanding text in each of the specialties? The specialists generally agree that no single text is completely self-sufficient. Perhaps the most important reason for this is the time required to prepare and publish such a text. This is particularly true in the dynamic field of pathology.

continued next page

★ Means highly recommended.

This text does admirably to cover the whole field in the light of recent advances. Many areas—oral pathology, virology, soft tissue tumors, fluid and electrolyte disturbances, to name a few—are obviously newly written. Histochemistry has been included in this edition, and the electron micrographs of nerve tumors, for example, are very interesting. All this is accomplished by a few less pages, but the print is now smaller and more compactly arranged.

It is ironical that in this edition, for the first time, the chapter on Heredity and Constitution was dropped. This deletion occurs at a time when the field of genetics is making rapid strides as a result of improved techniques utilizing tissue cultures for chromosomal analysis. The new exciting concept of abnormal chromosomal constitution as the underlying mechanism of congenital disorders is but a beginning of much to come.

PAUL Y. TAMURA, M.D.

★Epilepsy and Related Disorders

By William G. Lennox with Margaret A. Lennox, 1168 pp., $13.50, Little, Brown & Co., 1960.

TO ONE of his former students it is a great relief to find systematically recorded the ideas, experience, observations, teachings, and philosophies of one of the great leaders in the study of epilepsy. Dr. Lennox has devoted the major part of his life to investigation of the disease, the treatment of its victims and the education of students and the public.

This two-volume work is a mine of information in all aspects of epilepsy excepting detailed information on electroencephalograms and the neurosurgery of seizures. The text is a reference book, not something to skim through. There are a wealth of detailed statistics and further references. The reader's interest is maintained by many quotations from literature and other medical writers and also by many case histories.

This book is highly recommended. The paper is not shiny. The print is large and clear. The detailed table of contents and index make finding pertinent material easy, and there is a voluminous list of references.

JOHN J. LOWREY, M.D.

★Diagnosis and Therapy of the Glaucomas

By Bernard Becker, M.D., and Robert N. Shaffer, M.D., F.A.C.S., 360 pp., $18.00, The C. V. Mosby Company, 1961.

THIS NEW TEXT on the glaucomas will undoubtedly be in great demand because the work is presented in such an admirable manner. The authors have a rather definite point of view in the handling of the glaucoma patient and this is good for the student of ophthalmology, particularly when one considers the authoritative source of the information presented.

The authors have not attempted to make the text all-inclusive or definitive but have organized the material so that the reader can readily find specific information. At the end of each section there is a brief bibliography. The entire work is so well presented that the reader will find his interest constantly stimulated as he digests the valuable material available at his fingertips.

There are many fine illustrations, photographs, and diagrams to complete a text of tremendous practical value to the ophthalmologist. The sections on gonioscopy, tonometry, and tonography are superb. These will prove of great interest and value to the ophthalmologist searching for information in these important areas. The section on surgical technique will also stir one's interest in some of the finer details of glaucoma surgery. The authors will most assuredly receive many a "thank you" from the profession for this valuable addition to the literature.

H. F. MOFFAT, M.D.

The Spine, 2nd Ed.
A Radiological Text and Atlas

By Bernard S. Epstein, M.D., 616 pp., $16.50, Lea & Febiger, 1962.

THIS IS a well-illustrated and documented reference book on diseases of the spine and its anomalies. However, I would point out that paleontology precedes embryology and Epstein gives no space to the history of the spine in our remote antecedents. There he would find the background for the anomaly known as limbus body which is so important in medicolegal work. This throwback is too frequently referred to as a fracture, which it is not. It would even explain the presence of a portion of the disc between the intercalary bone, as it is sometimes called, and the subjacent vertebra.

S. F. STEWART, M.D.

★Atlas of Clinical Endocrinology, 2d Ed.

By H. Lisser, A.B., M.D., and Roberto F. Escamilla, A.B., M.D., 489 pp., $23.00, The C. V. Mosby Company, 1962.

UNLIKE MANY other excellent textbooks on the ever-growing field of endocrinology, this over-sized second edition is an extension of the first edition. Presenting a different approach to the learning and understanding of diseases—the pictorial approach—this pictorial atlas provides a simple and direct avenue toward recognition and understanding of the clinical endocrinopathies.

The authors have assembled extensive clinical data and portraits of the various endocrine disorders in an atlas format with concise, yet adequate text for the diagnosis and therapy. And in keeping with the host of new procedures available in endocrine diagnosis, they have attempted to include a reasonably complete and current recording of the most appropriate procedures—chemical, biological, roentgenological—for each disorder, supplemented by an appendix containing normal values for these tests.

Several newly described syndromes have been added, along with some modifications of the different sections. A number of chapters have been rewritten in the light of the newer findings, and the bibliographies following the discussion of each disorder have been greatly augmented with references through 1960.

No doubt, a pictorial atlas such as this will offer the busy and interested practicing physician an invaluable supplement to wordier textbooks on endocrinology.

EDWARD YAMADA, M.D.

★Metabolic Care of the Surgical Patient

By Francis D. Moore, M.D., 1011 pp., $20.00, W. B. Saunders Co., 1959.

THIS is probably the one and only book that discusses metabolism in normal and pathological states in the surgical patient. A large and luminous work by the well-known Dr. Francis D. Moore, it has excellent illustrations and graphs, and the contents are in simple outline, all of which makes reading this book a pleasure.

This book is recommended especially for those in the field of surgery.

WALLACE W. S. LOUI, M.D.

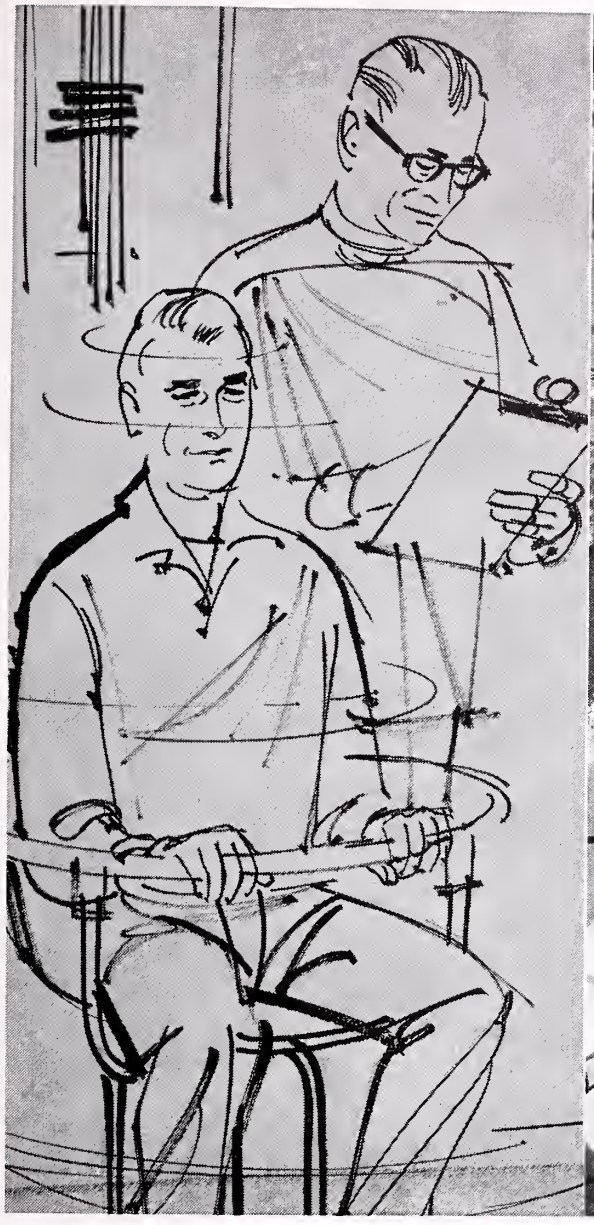
Also Received

Hemoglobin and Its Abnormalities

By Vernon M. Ingram, B.Sc., Ph.D., 153 pp., $7.50, Charles C. Thomas, 1961.

HEMATOLOGISTS need this authoritative volume, and pathologists, especially if they have forensic interests, would find it valuable.

continued page 442





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unique therapeutic achievement

in 1962
universal therapeutic acceptance

Dramamine® in vertigo

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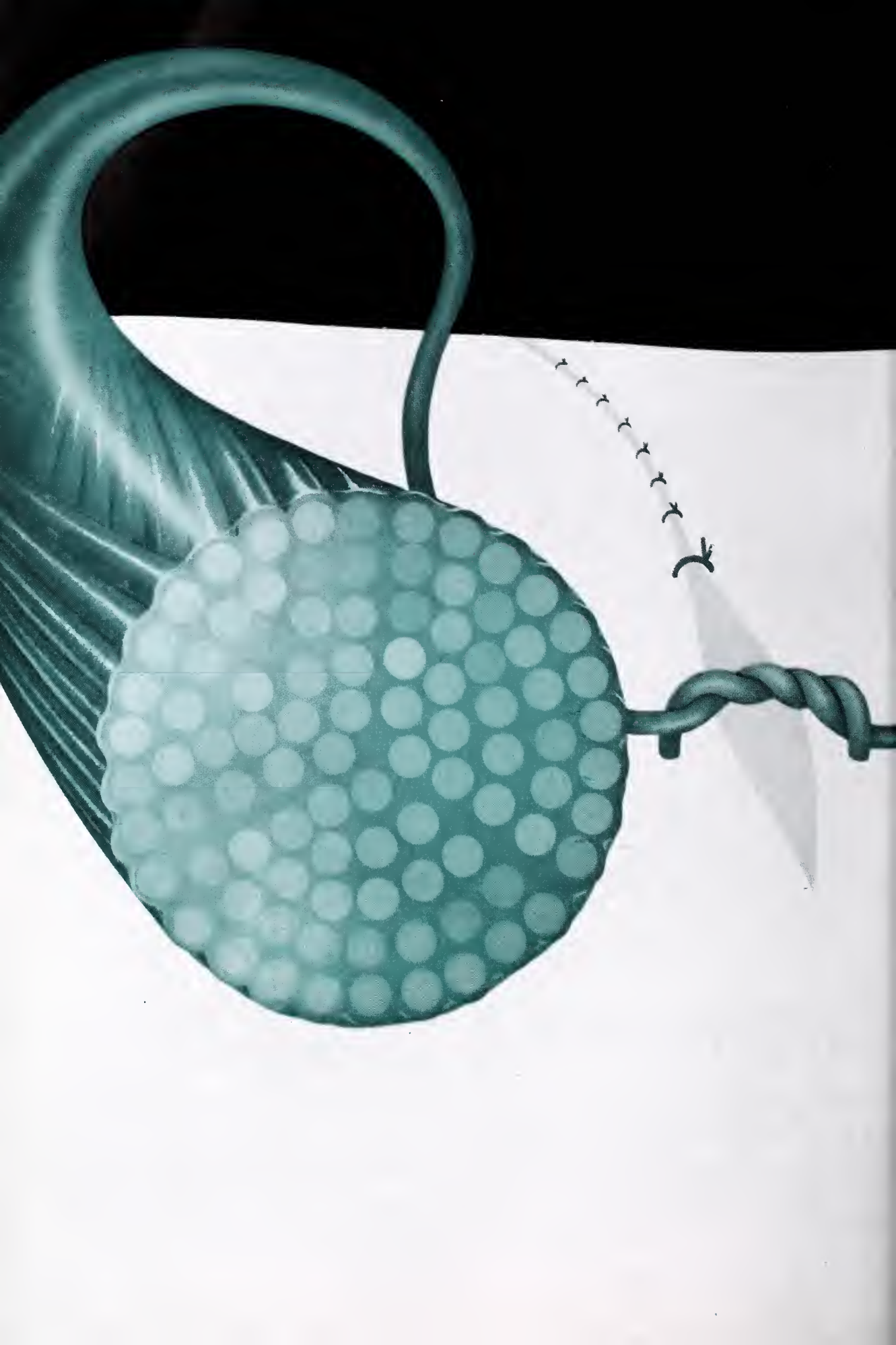
world standard for control of vertigo, nausea and emesis associated with

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ETHICON®

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Tassette®

INTERNAL MENSTRUAL CUP

Offers outstanding advantages over other internal and external methods.

Not a napkin, not a tampon, but a small, soft rubber cup. Anatomical shape nests securely in the vaginal cavity. Conforms to the shape of the vagina. Does not block or obstruct the cervix and allows free flow from the uterus . . . into this convenient 1 oz. receptacle.

Tassette provides a new dimension in comfort and hygienic protection, never before available.

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- Does not cause cramps
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- Small and convenient, easy to carry in purse or pocket
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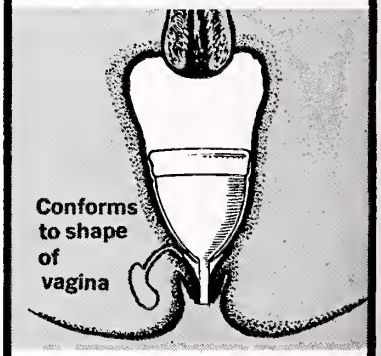
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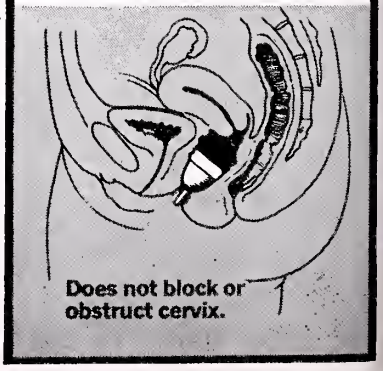
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*Problems Relative to the Reproduction of Microchemical Methods**

Recently, while attending the Central District Meeting of Technologists at Texarkana, this writer was approached by several technicians requesting specific information regarding some of the microchemical procedures they had tried to reproduce as new methods for their respective laboratories.

These people were having difficulty in getting standard curves to reproduce, or even compare, with those of the method which they had chosen. Others were not able to get proper color development for photometric readings, and some had various other problems.

Perhaps the following information, relative to some of these problems, might be of value to those who are now using or anticipate using, microchemical methods.

Before attempting to reproduce any chemical method, either micro or macro, one should first become acquainted with all available information concerning method, especially for microchemistries. At least, one should obtain a good text[1-2] on microanalysis.

Another excellent source of information is a medical library, from which may be obtained additional texts,[1-2] journals,[3-4] or other publications dealing with microchemistry.

Some of the reasons for reviewing given microchemical methods are: (1) It enables the technician to choose a method which utilizes the laboratory facilities at hand, possibly reducing the needs for additional equipment necessary for microanalysis. Comparing several methods for the same determination permits the selection of a less time-consuming method, which is an important factor from the standpoint of efficiency in work output. A comprehensive review of the chemical reactions occurring in a given method enables the technician to understand the mechanisms of the color development for a given method. (2) Such a review permits the technician to combine the best features of one or more similar methods, giving a modified method which better suits the particular laboratory situation. There is seldom any feature so rigid about a microchemical method that it cannot be changed to meet a given situation in a clinical laboratory, within limits. (3) The major consideration is to choose the method which will give the most accurate results.

In reviewing methods for a given procedure, it may be noted that the percentage of error ranges from less than one percent to as much as five percent. Since one of the advantages of microchemical methods is that the percentage of error can be greatly reduced from macro procedures, it is especially significant to strive for the method which gives the least possible percentage of error.

With these factors in mind, the following assumptions could be made:

1. A Folin-Wu micro glucose method has been selected as follows:

   a. Pipette 50 lambda of serum into the bottom of a 13 x 100 mm test tube.
   b. Add 1.0 ml of tungstic acid, mix well and centrifuge.
   c. Pipette 0.5 ml of clear supernatant to a 13 x 100 mm test tube.
   e. Add 0.5 ml of alkaline copper reagent to each and mix by tapping.
   f. Transfer the tubes to a metal rack and place in a boiling water bath. Set clock for 10 minutes.
   g. At 10 minutes add 0.5 ml of phosphomolybdic acid solution to each tube and leave in the boiling water bath for an additional 2 minutes.
   h. Remove rack to a cold water bath and let cool for 2 minutes.
   i. Add 2 ml of water to each tube. Mix thoroughly by inversion.
   j. Transfer to 12 x 75 mm cuvets.
   k. Set the Coleman Jr. to zero OD with the blank at 420 mu. Read OD of unknown and obtain value from calibration curve or by the use of a factor. (The standard calibration curve is essentially linear to 500 mg%.)

2. The method as given was reproduced on three separate occasions. On each occasion, a standard curve and four serum determinations were run, using aliquots of the same serum for all three occasions.

3. The same equipment, chemicals, concentrations of solutions, glassware, etc., were used as prescribed in the above method.

4. Analysis of the three sets of determinations indicate that:

   a. The standard curves are linear to the 350 mg% level, but not to 500 mg% as indicated.
   b. The OD of the glucose standards are reproducible in all three sets of determinations.
   c. The serum determinations failed to reproduce comparable optical densities.

* First published by the Arkansas Society of Medical Technologists.

These discrepancies may be eliminated by carefully reviewing each step of the method and making adjustments as indicated by the analysis. Step (a) seems to be the most logical place to begin correcting errors in the serum determinations. The optical densities were not reproducible for the serum determinations, but were reproducible for the glucose standards, indicating a possible discrepancy in pipetting.

This discrepancy may be overcome in one of two ways. First, interchange steps (a) and (b). Second, rinse out the micropipettes with 50 lambda of distilled water, repeating this procedure three additional times. This would ensure more accurate delivery of the serum, as experience has shown that washing out the serum from micropipettes gives consistent and reproducible results. Step (b) could be changed to read "add 0.8 ml tungstic acid to step (a)," if the second choice in correcting step (a) were used. There is enough tungstic acid present in 0.8 ml to precipitate the protein in the serum in step (a), and the dilution ratio remains the same. Steps (c), (d), and (e) need no elaboration, except to say that 500-lambda pipettes may be used.

In step (f), the efficiency of the method may be improved by adding marbles as covers for the tubes to prevent splashings of the boiling water from entering the tubes. However, since the glucose standards were reproducible, this technique is not likely to be a source of error in the method. Step (g) needs no adjustment or comment.

Step (h) is important in that cooling stops the chemical reaction contributing to the final color development. Although it does not seem to have any bearing on this particular problem, an ice water bath for constant temperature control is preferable to a cold water bath, since the cold water bath implies use of tap water, and varies in temperature. Steps (i), (j), and (k) need no elaboration and have no bearing on the discrepancy of the serum determinations.

The discrepancy concerning the inability to reproduce a linear standard curve to 500 mg % does not involve any steps in the method, with the possible exception of step (k). In step (k), the use of a spectrophotometer may or may not have any bearing on the inability to establish a standard curve linear to the 500 mg % level.

This error, if it can be called an error, may occur in two ways. First, it is possible that an error may have been made in the concentrations of the glucose standards, in which case a new set of standard solutions can be made. Secondly, the spectrophotometer might have been out of calibration.

On a Coleman Jr. spectrophotometer this may be ascertained by rechecking the wave length setting with a didynium filter provided for just such procedures. If both of these possibilities have been checked and no error found, a standard curve may be established up to 350 mg % disregarding the nonlinear portion of the standard curve. This statement is based on the following facts. (1) The absorbance of a colored solution as measured by spectrophotometers is directly proportional to its concentration. For example, an aliquot of serum has a theoretical glucose concentration of 500 mg % and an optical density reading of 1.0. A 1 : 10 dilution of the final colored solution would reduce the reading of the optical density comparable to that of a 50 mg % glucose solution. Therefore, the nonlinear portion of the standard curve could be disregarded. (2) Accurate readings on a spectrophotometer are limited to 15 to 85 percent transmittance. Any reading beyond these limits increases the percentage of error. (3) It is neither necessary nor always possible to reproduce the same standard curve as outlined in a particular method, because of the inherent characteristic differences found in spectrophotometers.

Perhaps the above information will be of some assistance to those already working with micro methods, and encourage others to avail themselves of the advantages these methods afford. •

CARL B. FERRELL, M.A., *Physiologist*
Med. Res. Lab., Veterans Administration Hospital, Little Rock, Ark.

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4. Clinical Chemistry, Paul B. Hoebert, Inc., 49 E. 33rd St., New York 16, New York.

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1. Ford, R. A., and Blanchard, K: Journal-Lancet 78:185, 1958.

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A Physician's Introduction to Electronics

By A. C. Morris, Jr., 43 pp., $2.50, Pergamon Press, Ltd., 1961.

"THE PRIMARY purpose of this document is to teach non-electronically-minded physicians that the proper procedure in the case of malfunction is to call an electronics expert."

Psychopathology of Aging

Edited by Paul H. Hoch, M.D., and Joseph Zubin, Ph.D., 321 pp., $9.75, Grune & Stratton, 1961.

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Respiration in Health and Disease

By R. M. Cherniack, M.D., and L. Cherniack, M.D., 403 pp., $10.50, W. B. Saunders Company, 1961.

THIS SOMEWHAT didactic text is aimed at undergraduate students rather than practicing physicians.

★Handbook of Emergency Toxicology

By Sidney Kaye, M.Sc., Ph.D., 377 pp., $10.75, Charles C. Thomas, 1961.

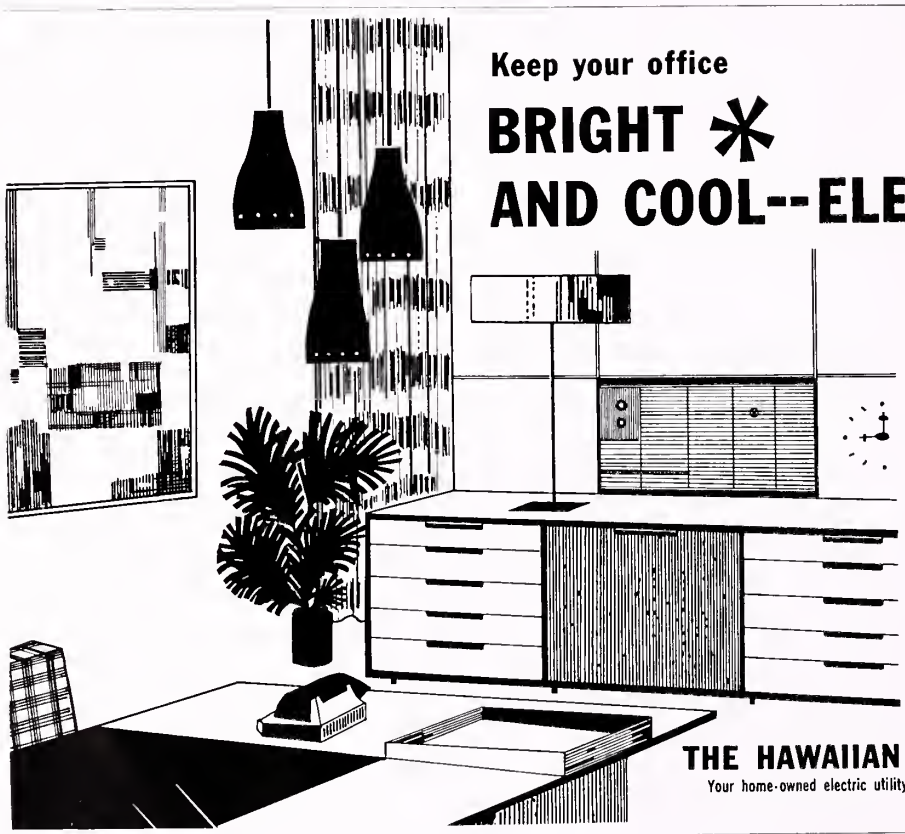
INDISPENSABLE, handy, practical reference work. Seventy pages of trade names and the significant toxic ingredient in each. Good index.

Executives' Health Secrets

By William P. Shepard, M.D., 268 pp., $4.95, The Bobbs-Merrill Company, 1961.

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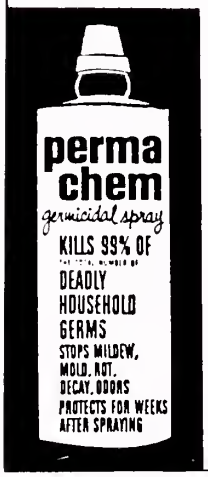
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*Journal of AMA, April 4, 1959 Vol. 169 pp 1549-1556

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★Microtechniques of Clinical Chemistry

By Samuel Natelson, Sc.M., Ph.D., 578 pp., $14.75, Charles C. Thomas, 1961.

CLINICAL pathologists will find helpful this beautifully printed laboratory manual with over 2,000 author references.

Immunity

By Sidney Raffel, Sc.D., M.D., 646 pp., $10.00, Appleton-Century-Crofts, Inc., 1961.

A LITTLE deep for the average physician. First new edition in eight years.

British Medical Bulletin, Vol. 17, No. 3

Sir William MacArthur, Advisory Editor, pp. 177-264, Medical Department, The British Council, 1961.

A GENERAL view of the field of human genetics.

Measurements of Exocrine and Endocrine Functions of the Pancreas

By F. William Sunderman, M.D., Ph.D., Sc.D., and F. William Sunderman, Jr., M.D., 203 pp., $11.00, J. B. Lippincott Co., 1961.

TWO INTERNISTS at Jefferson bring the laboratory to the bedside of the patient with a sick pancreas.

The Surgical Clinics of North America, Vol. 41, No. 6

Crawford J. Campbell, M.D., Guest Editor, pp. 1451-1787, W. B. Saunders Co., December, 1961.

THIS NATIONWIDE number on orthopedic management also includes a three-year cumulative index.

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Biological Activity of the Leucocyte

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A., 120 pp., $2.50, Little, Brown and Company, 1961.

WILL lymphocytes stick to glass, as granulocytes do? *Are* circulatory leucocytes comparable to tissue leucocytes? *What* functions do leucocytes perform? Read *all* about it!

★Resuscitation of the Unconscious Victim, 2d Ed.

By Peter Safar, M.D., 87 pp., $2.00, Charles C. Thomas, 1961.

SHOULD be required reading for first-aid men, ambulance attendants, and anyone who has to teach resuscitation. A pocket size manual, with plenty of diagrams.

★Disturbances of Heart Rate, Rhythm and Conduction

By Eliot Corday, M.D., F.A.C.P., F.A.C.C., and David W. Irving, M.D., 357 pp., $8.50, W. B. Saunders Co., 1961.

CARDIAC arrhythmias, beautifully organized and presented by both authors and publisher.

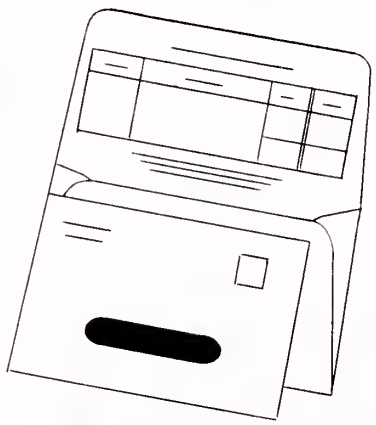
★Progress in Liver Diseases

Edited by Hans Popper, M.D., Ph.D., and Fenton Schaffner, M.D., M.S., 363 pp., $13.75, Grune & Stratton, 1961.

THE editors and 36 world-wide contributors bring liver disease up to date, with electron microscope and radioisotopic studies, in 24 well-illustrated and well-documented articles. There is a 13-page index.

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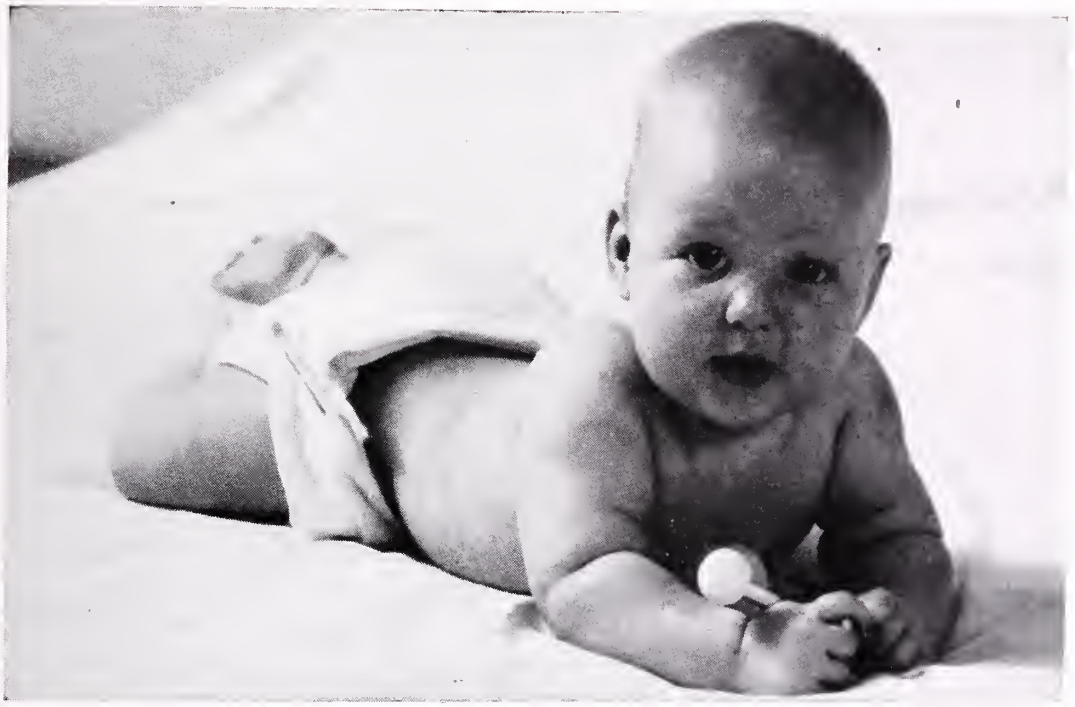
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1. Smith, C. H.: Blood Diseases of Infancy and Childhood, St. Louis, C. V. Mosby Co., 1960, p. 159.
2. Guest, G. M., and Brown, E. W.: AMA J Dis Child **93**:486 (May) 1957.

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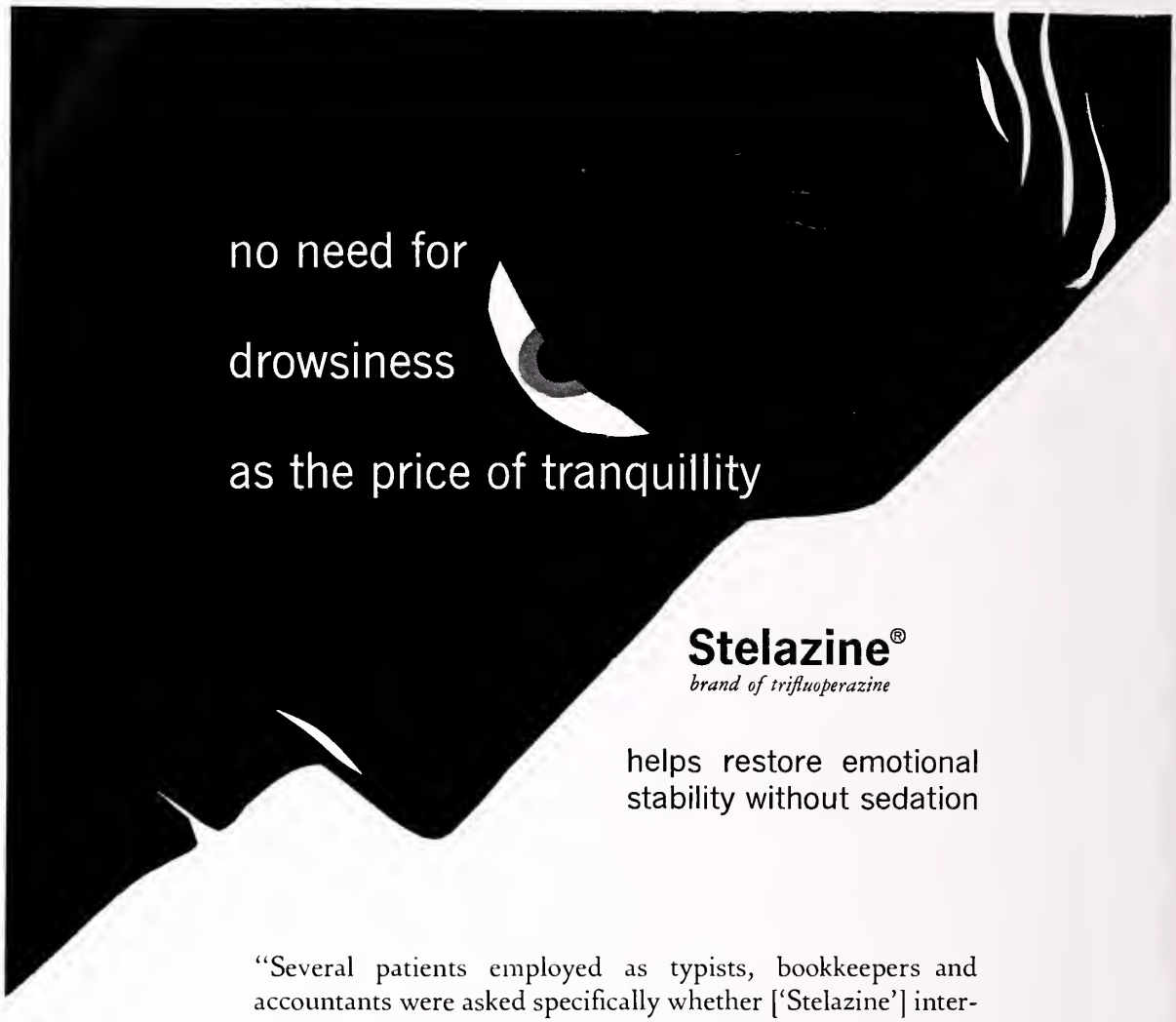
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1. Ernst, E.A.: in *Trifluoperazine: Further Clinical and Laboratory Studies,* Philadelphia, Lea & Febiger, 1959, pp. 104-109.
2. Bram, G.: The Treatment of Psychoneurotic Conditions with Trifluoperazine, Brit. J. Clin. Pract. *14*:107 (Feb.) 1960.

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Book Reviews *continued from 446*

Hemodynamics of Aortic and Mitral Valve Disease

By Alvin J. Gordon, M.D., Paul A. Kirschner, M.D., and Howard L. Moscovitz, M.D., 136 pp., $5.75, Grune & Stratton, 1961.

TRANSBRONCHIAL left heart catheterization, beautifully presented. Of absorbing interest to cardiovascular surgeons and cardiopulmonary physiologists.

★Differentiation Between Normal and Abnormal in Electrocardiography

By Ernst Simonson, M.D., 328 pp., $13.50, The C. V. Mosby Co., 1961.

A CLOSE, *close* look at standards and variables in electrocardiography. Strictly for cardiologists.

The Mold of Murder

By Walter Bromberg, M.D., 229 pp., $4.50, Grune & Stratton, Inc., 1961.

LURID rather than instructive, and carelessly edited.

Medicine in Tropical Africa

By Michael Gelfand, C.B.E., M.D., F.R.C.P., D.P.H., D.M.R., 243 pp., $7.00, The Williams & Wilkins Co., 1961.

INDISPENSABLE to a physician planning to practice in Africa.

Psychiatry, Biological and Social

By Ian Gregory, M.A., M.D., D.Psych., M.P.H., 577 pp., $10.00, W. B. Saunders Co., 1961.

FOR medical students primarily. An orderly presentation, however, which would be helpful to interested physicians.

continued page 454

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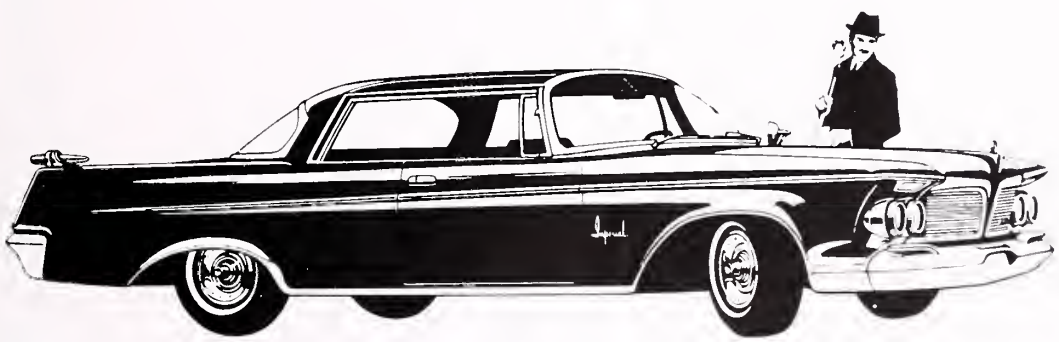
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Book Reviews *continued from 452*

★Practical Pediatric Dermatology

By Morris Leider, M.D., 437 pp., $13.25, The C. V. Mosby Co., 1961.

THIS CONCISE, authoritative, well-illustrated, scholarly yet practical textbook is worth having on your desk for ready reference.

Pre-Nursing Course in Science

By John M. Munro, M.A., B.Sc., 147 pp., $3.50, E. & S. Livingstone Ltd., 1961.

ELEMENTARY science clearly, if somewhat Britishly, presented.

The Surgical Clinics of North America, Vol. 42, No. 1

Leo M. Zimmerman, Guest Editor, Pp. 1-270, W. B. Saunders Company, February, 1962.

APPLIED PHYSIOLOGY in Surgical Disease. Thirty contributors.

Midwifery by Ten Teachers, 10th Ed.

Edited by Frederick W. Roques, C.B.E., M.D., M. Chir, F.R.C.S., F.R.C.O.G., John Beattie, and Joseph Wrigley, 739 pp., $9.00, The Williams & Wilkins Co., 1961.

TEN EDITIONS in 44 years speak for themselves. A British presentation of obstetrics, for students.

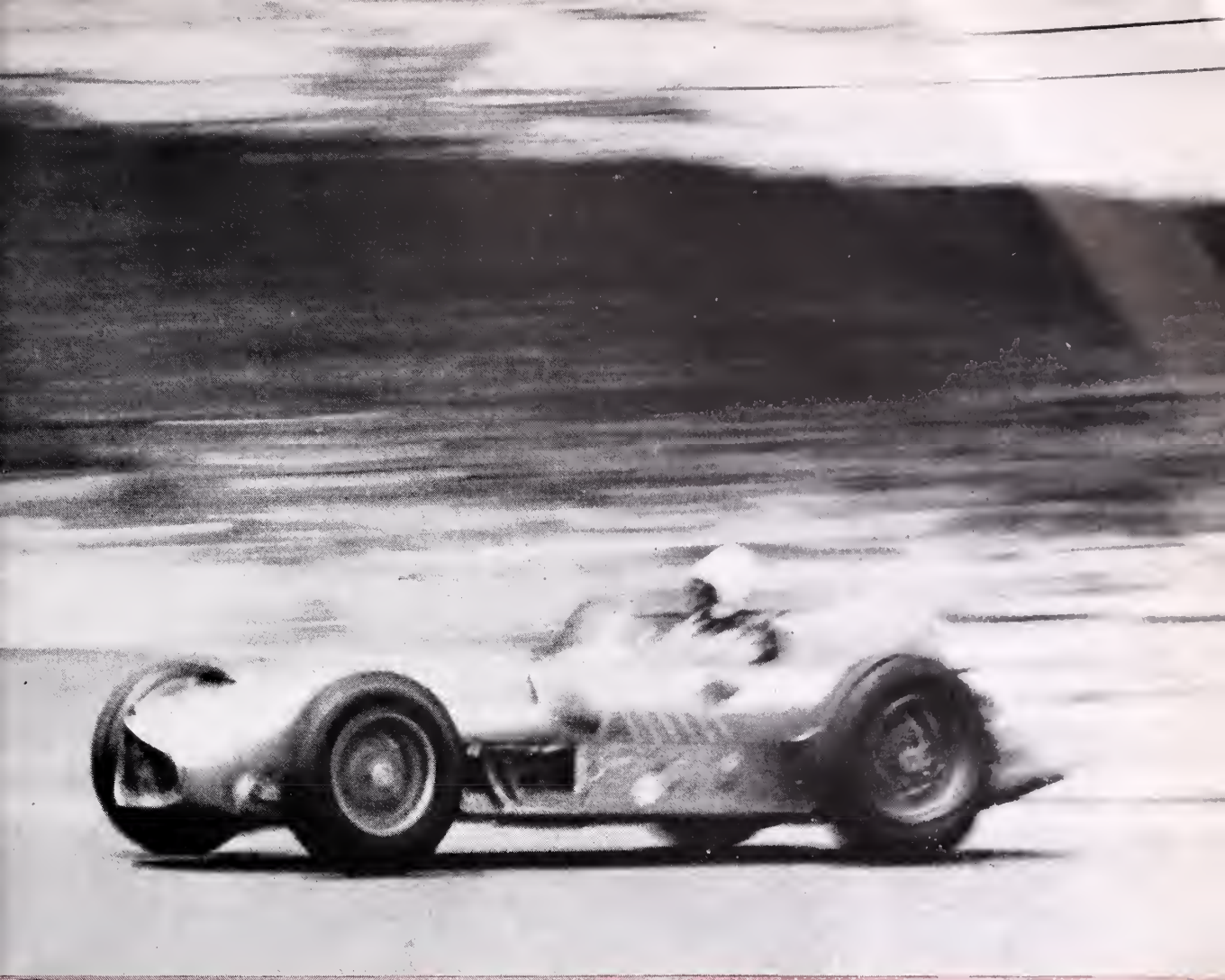
Halothane (Fluothane)

By C. Ronald Stephen, B.Sc., M.D., C.M., and David M. Little, Jr., M.D., 141 pp., $6.00, The Williams & Wilkins Co., 1961.

ANESTHESIOLOGISTS should read this. There are 338 references!

continued page 456





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★Proceedings of the Third Conference on Cardiovascular Diseases

Edited by Clark H. Millikan, Robert G. Siekert, and Jack P. Whisnant, 247 pp., $5.75, Grune & Stratton, 1961.

FIFTY-SIX contributors presented and discussed various aspects of strokes at a conference last January. Surgical intervention is discussed in detail by DeBakey and others.

Annals of the New York Academy of Sciences, Vol. 93, Art. 4

By Minoru Tsutsui, Franklin N. Furness, Editor, 135-146 pp., The New York Academy of Sciences, December, 1961.

THIS PAPER on "Complex Mechanism of Catalysis: The Aryl-Coupling Reaction" received an A. Cressy Morrison Award in Natural Science in 1960 from the New York Academy of Sciences.

Annals of the New York Academy of Sciences, Vol. 94, Art. 1

George T. Dimopoullos, Conference Editor, pp. 1-335, 1961.

A SERIES of papers which were presented at a conference on plasma proteins in health and disease.

Annals of the New York Academy of Sciences, Vol. 94, Art. 3

Felix Wroblewski, Conference Editor, pp. 655-1030, 1961.

A SERIES of papers which were presented at a conference entitled "Multiple Molecular Forms of Enzymes."

Annals of the New York Academy of Sciences, Vol. 95, Art. 2

Charles M. Pomerat, Conference Editor, pp. 741-1020, 1961.

A SYMPOSIUM on the use of animal cell, tissue, and organ cultures in radiobiology.

A Manual of Neurology and Psychiatry

By Ralph T. Collins, A.B., M.D., Med.Sc.D., 244 pp., $6.50, Grune & Stratton, 1961.

A USEFUL manual, especially for doctors who do much Workmen's Compensation work.

The Medical Clinics of North America, Vol. 45, No. 5

J. Sydney Stillman, M.D., Guest Editor, pp. 1115-1386, W. B. Saunders Co., September, 1961.

A SYMPOSIUM on arthritis and rheumatism.

The Medical Clinics of North America, Vol. 45, No. 6

Michael G. Wohl, M.D., Guest Editor, pp. 1387-1757, W. B. Saunders Co., November, 1961.

A VOLUME on office practice and procedures dedicated to the American Academy of General Practice.

The Medical Clinics of North America, Vol. 46, No. 1

Louis Limarzi, M.D., Guest Editor, pp. 1-306, W. B. Saunders Co., January, 1962.

NEW clinical and experimental data on the spleen and blood.

British Medical Bulletin, Vol. 18, No. 1

W. Hayes, Scientific Editor, pp. 1-88, Medical Department, The British Council, 1962.

SIXTEEN articles on the genetics of germs.

Introduction to Anesthesia, the Principles of Safe Practice, 2d Ed.

By Robert D. Dripps, M.D., James E. Eckenhoff, M.D., and Leroy D. Vandam, M.D., 413 pp., $4.75, W. B. Saunders Co., 1961.

UNIVERSITY OF PENNSYLVANIA anesthesiology manual, brought up to date and polished.

Mechanisms of Disease An Introduction to Pathology

By Ruy Perez-Tamayo, M.D., 512 pp., $14.00, W. B. Saunders Co., 1961.

AN INTRODUCTION to pathology, and a good one. Primarily for undergraduate students.

★Medical Physiology, 11th Ed.

Edited by Philip Bard, 1339 pp., $16.50, The C. V. Mosby Co., 1961.

SIXTEEN distinguished contributors have produced a fine new edition—the first in five years—of this standard text.

Pediatric Clinics of North America, Vol. 8, No 4

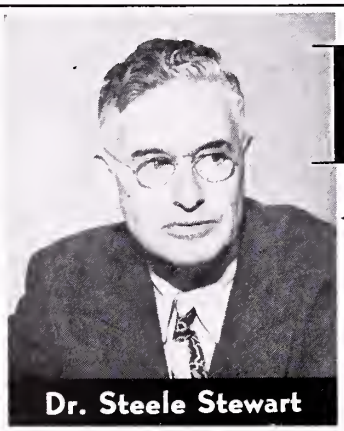
Benjamin M. Kagan, M.D., Consulting Editor, pp. 967-1371, W. B. Saunders Co., November, 1961.

AN up-to-date review of current knowledge of antimicrobial therapy.

Hypertension: Recent Advances

Edited by Albert N. Brest, M.D., and John H. Moyer, M.D., 660 pp., $12.00, Lea & Febriger, 1961.

OVER 120 contributors from various countries speak their mind at the second Hahnemann Symposium, held last May. Verbatim discussions. ●



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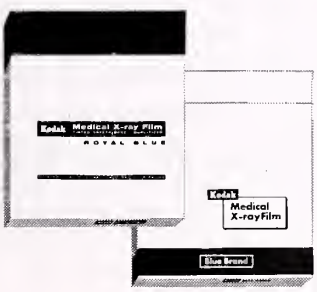
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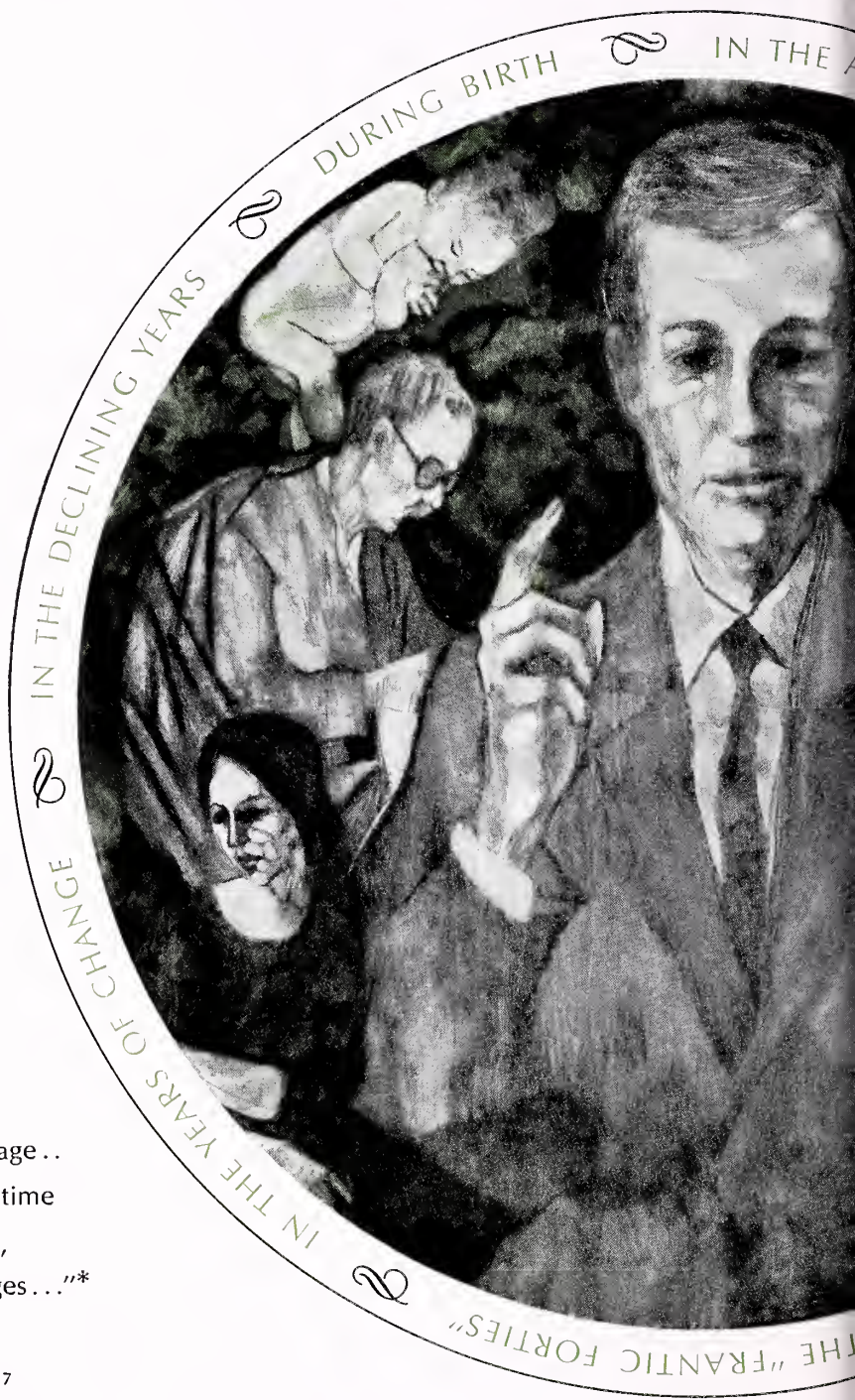
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*As You Like It, Act II, Sc. 7

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

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PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

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Notes and News *continued from 430*

Dr. Fred Giles' remarks on the King-Anderson Bill were given good coverage. Ditto **Dr. Toru Nishigaya's.**

Dr. C. F. Chang found his new car stripped right in his own garage.

Getting into the big time, **Dr. Walter Quisenberry's** observations on the local stomach cancer problem were widely quoted in *Time* magazine and locally.

Dr. Harry L. Arnold, Jr., was re-elected a director of the Honolulu Automobile Club.

Condolences to **Dr. and Mrs. Edmund Tompkins,** whose daughter was fatally injured in a traffic accident in Texas.

Dr. Robert Chung is a new director of the Honolulu Community Chest.

HMA's medical pilgrimage to Samoa is gaining momentum. To date **Drs. Thomas Richert, Verne Waite,** and **Edward Boone** have spent time there to help the Samoans. **Dr. B. A. Richardson** is slated to go next.

Dr. K. S. Tom is much in the news lately, as a speaker in his own native language (he has few peers) and as the president of the Tom Society.

Dr. William N. Bergin was guest editor of the *Hilo Tribune Herald* on March 22. His editorial was on "Medical Care for the Aged is Everybody's Problem." It was timely and apropros.

Dr. Casimer Jasinski spoke to students and parents at Kalani High School on civil defense. He was also on radio with **Dr. Edward Boone** to discuss family training to meet emergency problems.

Poison experts, **Drs. Richard K. B. Ho** and **J. C. Carson,** presented their views ably on TV recently. ●

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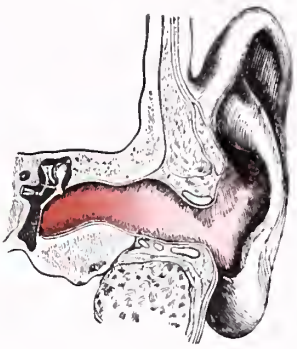
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Literature available on request.

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Our "Angels"

	Page
American Tobacco Company	393
Ames Company, Inc.	396, 463
Ayerst Laboratories	464
Baxter, Don	443
Burroughs Wellcome Co.	388, 394, 437, 461
Carnation Co.	395
Chrones Building	442
Ciba Pharmaceuticals	400
Coca-Cola Bottling Co. of Honolulu	454
Endo Laboratories	455
Ethicon, Inc.	434, 435
Hawaii Medical Service Association	426
Hawaiian Air Lines	454
Hawaiian Electric Co., Ltd.	442
Health-Mor, Inc.	448, 449
International Latex Corp.	390, 391
International Travel	456
Kodak Hawaii	457
Lederle Laboratories	451
Lilly, Eli, & Co.	381, 402
Lorillard, P., & Co.	399
Mead Johnson & Co.	397
Medical Industries	462
Medical Placement Bureau	452
O'Leary, Lydia	446
Optical Dispensers	442
Pacific West Distributors, Ltd.	444
Parke, Davis & Co.	382, 383
Professional Services, Inc.	444
Pfizer Laboratories	458, 459, 460
Robins, A. H., Co., Inc.	389, 441
Ross Laboratories	447
Saunders, W. B., Co.	385
Schering Corporation	401
Schuman Carriage Co., Ltd.	440
Searle, G. D., & Co.	433
Smith, Kline & French	450
Star-Bulletin Printing Co., Inc.	446
Summers, Clinton D.	460
Tailby Nason Co.	445
Tassette, Inc.	436
Universal Motors	453
Von Hamm-Young Co., Ltd.	440
Warren-Teed Products	392
Williams Mortuary	462
Winthrop Laboratories	387

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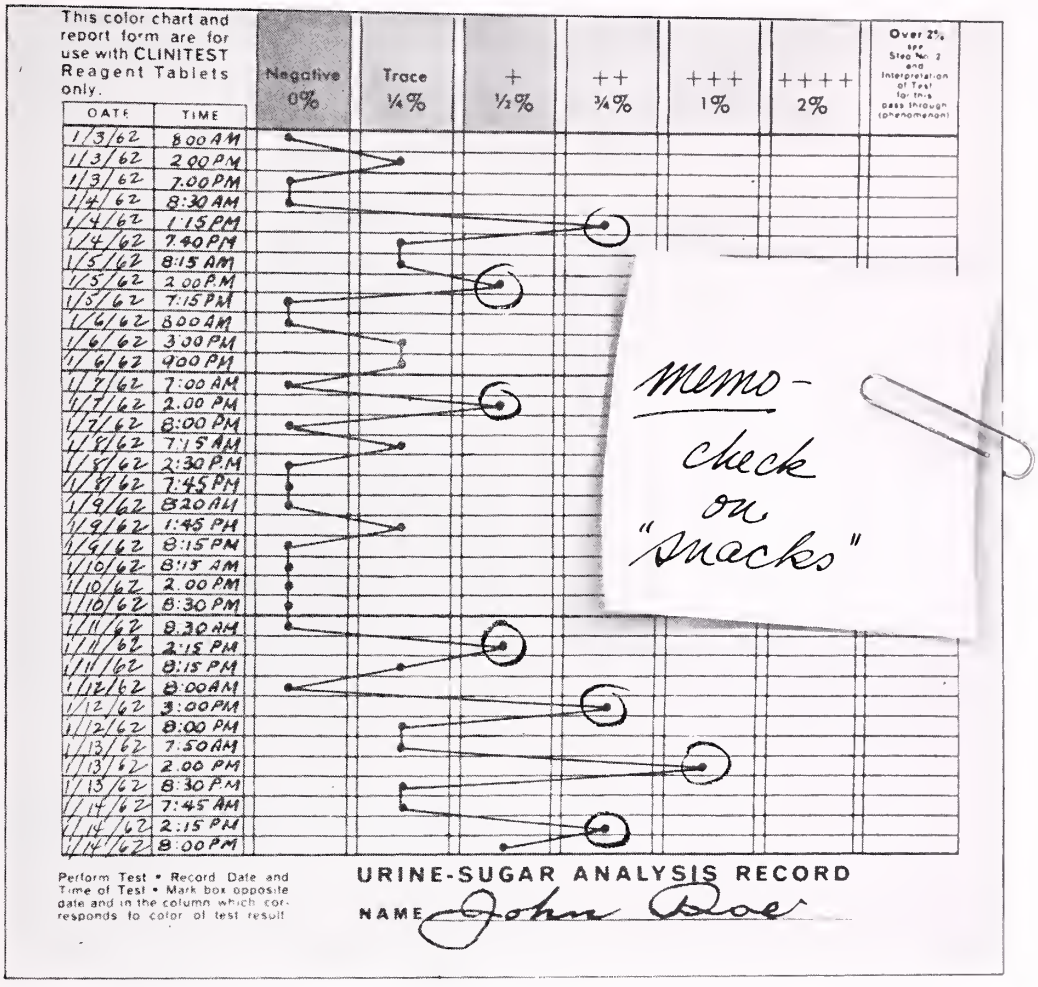
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2. Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. 73:43 (Jan.) 1961.

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ANNUAL INDEX

Table of contents, page 470

VOLUME 21 • NUMBER 6

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References: (1) Minchew, B. H., & Cluff, L. E.: *J. Chron. Dis.* **13**:354, 1961. (2) Wallmark, G., & Finland, M.: *Am. J. M. Sc.* **242**:279, 1961. (3) Wallmark, G., & Finland, M.: *J.A.M.A.* **175**:886, 1961. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Hodgman, J. E.: *Pediat. Clin. North America* **8**:1027, 1961. (6) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. (7) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (8) Goodier, T. E. W., & Parry, W. R.: *Loncet* **1**:356, 1959.

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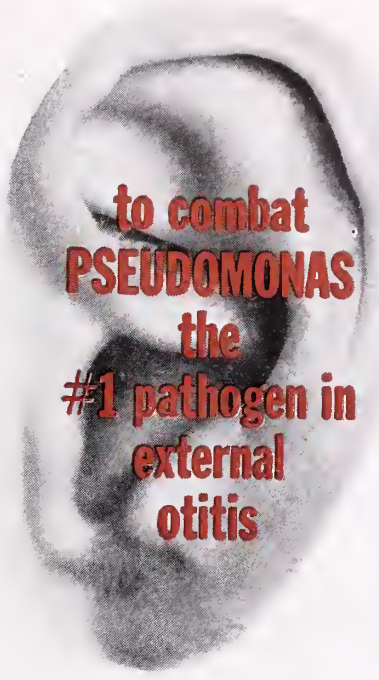
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Contents

Volume 21, Number 6, July-August, 1962

Articles

A Victory for Reason or for Emotion? 487
Leonard W. Larson, M.D.

Presidential Address 490
J. Alfred Burden, M.D.

Electromyography and Electrical Stimulation: A Brief Survey of Clinical Uses 492
Michael M. Okihiro, M.D.

Antibiotic Treatment of Staphylococcal Disease 495
D. E. Torin, Captain, MC

Primary Hyperthyroidism, A Symposium 499
Stephen Schwartz, M.D., John Ambrose, M.D., Jack Scaff, M.D., James Miyashiro, M.D., and Louis S. Rockett, M.D.

Editorials

The Service Concept and Social Security 505
Glue Sniffing 505

Features

Book Reviews 509
Correspondence 514
County Society News 511
Hawaii Medical Association 519
In Memoriam—Doctors of Hawaii—XXXIX 506
New Members 510
Our New President 518
President's Page 504
Reports and Snorts 482
This Is What's New! 507

Hawaii Technologists' Bulletin

Some Common Problems Encountered in Blood Banking 550



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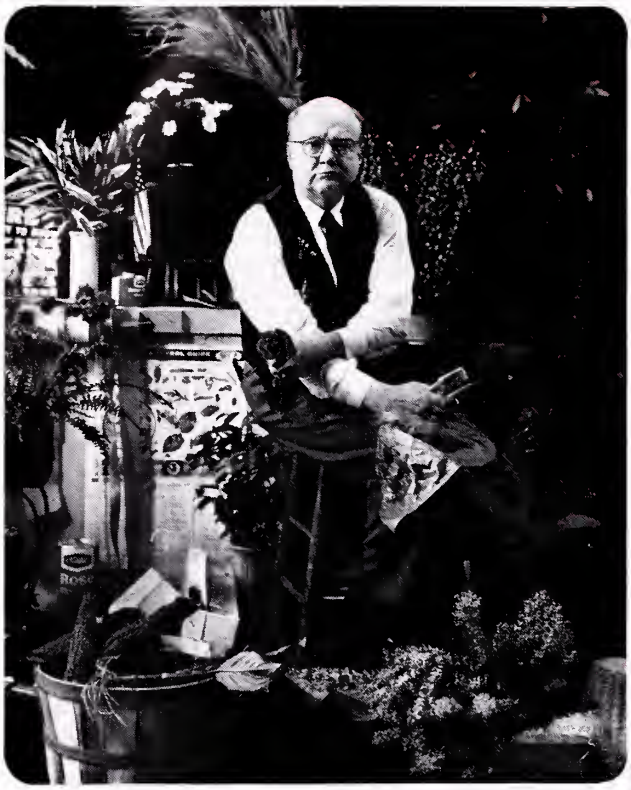
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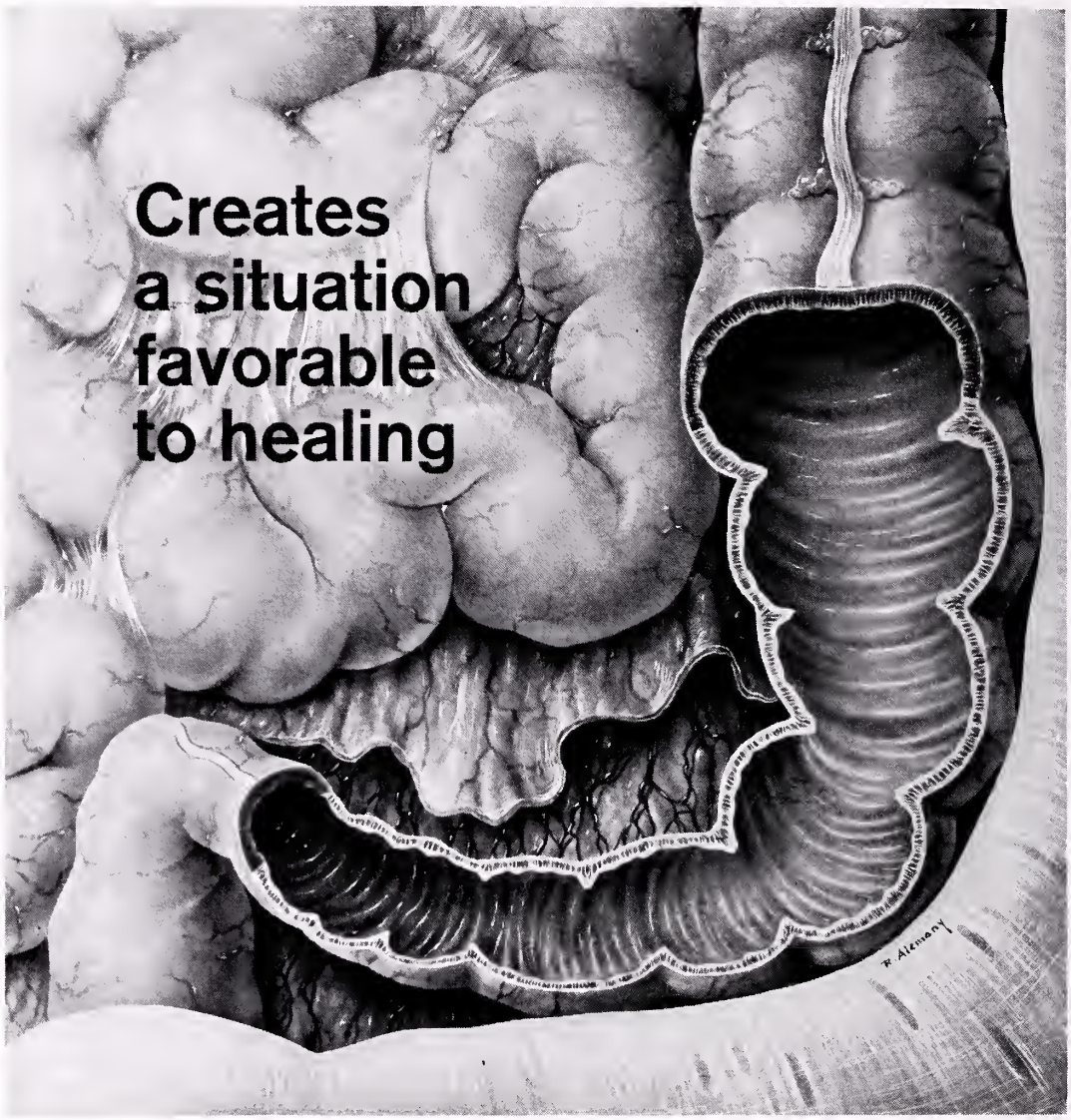
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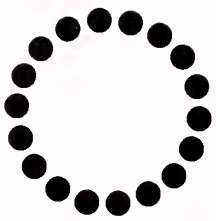
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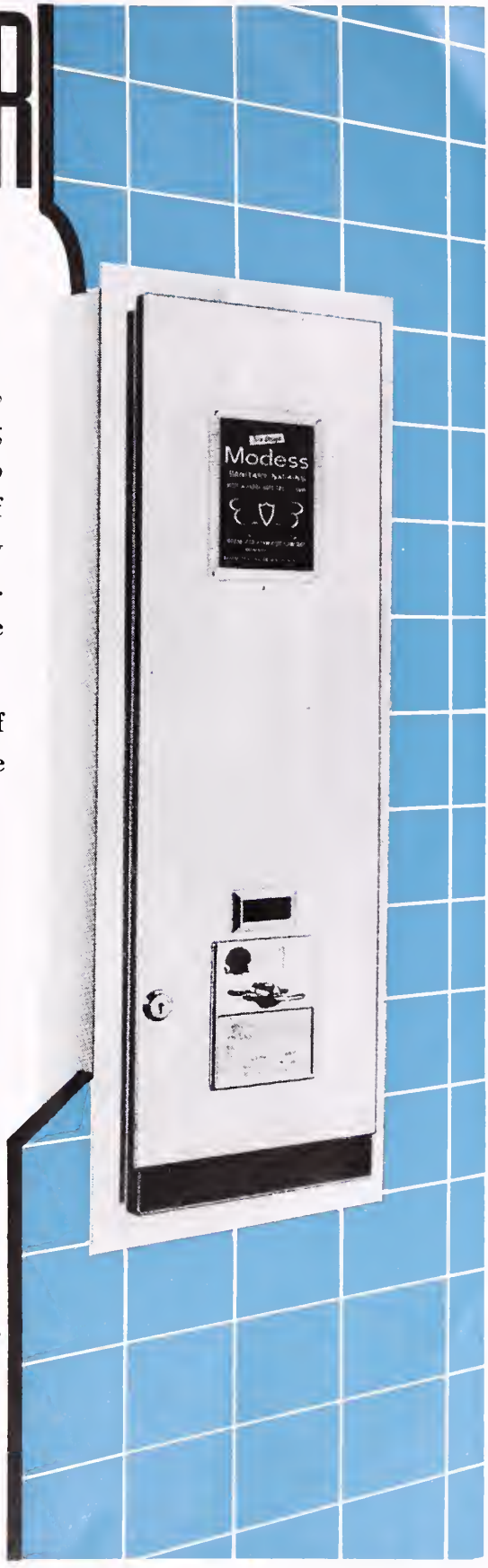
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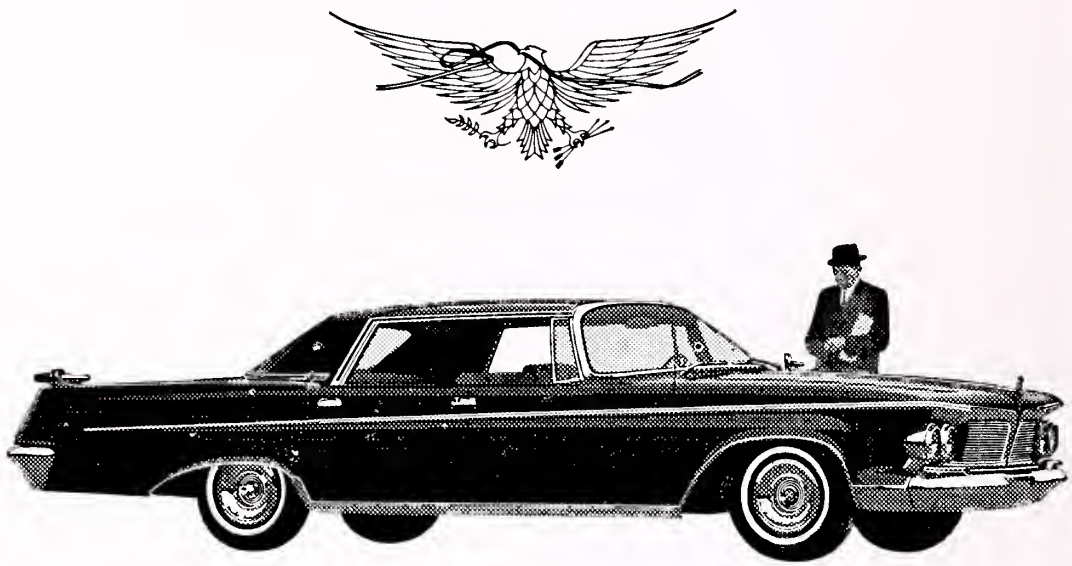
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A Victory for Reason or for Emotion?

LEONARD W. LARSON, M.D., *Bismarck, N. D.*

I AM delighted to be here tonight at the 106th Annual Meeting of the Hawaii Medical Association. Since becoming President-elect of the American Medical Association I have been in almost every one of the 50 states, and I am grateful for the opportunity to be here in Hawaii to visit and to speak to you before my term of office is concluded. Since Mrs. Larson and I arrived, you have been most gracious and we have enjoyed your wonderful hospitality and the beauty that is only Hawaii's.

Tonight I bring to you the warm and sincere greetings of the American Medical Association and all its members, the officers, and the Board of Trustees. We all wish you a most successful and outstanding medical meeting.

In the American Medical Association we are proud to have had the Hawaii Medical Association represented in the AMA House of Delegates since 1904. Your delegates have contributed much to the deliberations and actions of your House of Delegates.

In recent months I have traveled a good deal—much of it has been in the warmer climates of the United States where many medical meetings are held during the winter months. Without exception, I have found hundreds and hundreds of our elderly citizens either living in these areas or traveling in them.

HIGH PRESSURE CAMPAIGNS

Even now the Administration has opened its big push to get 14 million aged under a Social Security scheme to finance some hospital care. The Administration has opened its big push to get the King-Anderson bill, H.R. 4222, out of the House Ways and Means Committee to a vote on the House and Senate floor. This month the pressure by the Administration, the AFL-CIO and the National Council for Senior Citizens will be almost unbelieveable. Make no mistake about it, either: the White House is calling the shots in the tremendous efforts being exerted to get the financing of some medical care for the aged under the Social Security system.

In its April 2 issue, *Newsweek* magazine made this quite clear when it quoted Blue Carstenson, executive head of the National Council for Senior Citizens and a former member of the Department of Health, Education and Welfare. He said, "We generate the steam among the constitutents and the White House calls the shots." You can expect Administration officials to make more and more appearances around the country. One Administration spokesman even said that "if things bog down, top officials from Washington will make live appearances to pump new blood in the sagging area."

All state and county medical societies, thousands of physicians and their wives, and hundreds of our allies are deeply involved in scores of ways to defeat this unnecessary, costly, and bad legislation. If you haven't joined in these efforts and if you haven't done anything yet, do not wait an hour longer. I urge you to get active now. Your delay and apathy could mean the difference between victory and defeat. Perhaps there isn't a man or woman here who needs such an exhortation to get into the fight. If not, then I urge each of you to take the message to those colleagues and friends of yours who up until now have been too busy and have not taken the time to do their part.

We oppose this legislation because we believe the measure would be detrimental to the public interest. The King-Anderson bill is bad legislation and a dangerous proposal, and for some time now the AMA has been telling the full facts about this bill for financing certain medical benefits for the elderly through an increase in the Social Security tax.

FACTS IGNORED

Among the facts we believe of interest to the people is that the King-Anderson bill would provide hospital care to everyone over 65 eligible for

Delivered at the 106th Annual Meeting of the Hawaii Medical Association, May 5, 1962.

Social Security benefits regardless of need, regardless of their income or other resources, regardless of their present coverage of their medical care costs by voluntary health insurance. Yes, it is a fact that wage-earners and their employers would be compelled to pick up the bill for medical expenses of millions of the aged who are able to pay their own way and who want to keep it that way. But proponents of the King-Anderson bill have a curious allergy to facts such as these. They react with violent attacks on the AMA, attacks which have nothing whatever to do with the bill itself.

The issue is the King-Anderson bill—its costs, its taxes, its regulations and controls of hospitals and physicians, and its future. The issue is not the Administration or personalities; it is not Democrats or Republicans; it is not the AMA or the AFL-CIO, and it is not medical care for the aged or no medical care for the elderly. I repeat that the issue is the King-Anderson bill, all its implications and complications and all its fine print.

NEED EXAGGERATED

The basic issue of the King-Anderson bill is this: Should wage-earners and their employers be forced to pay higher Social Security taxes to provide hospital care for millions of others who are financially able to take care of themselves? Hospital care for the aged is not in dispute. Everyone agrees that all our citizens should be provided whatever hospital care they require. Those who are in need of financial help with their hospital expenses should be helped. And under the Kerr-Mills Medical Assistance for the Aged Law, the needy and the near-needy elderly will get the full assistance they require.

For those who can afford to pay their own way, voluntary health insurance is the answer. Already more than 53 per cent of all persons over 65 have some kind of voluntary health insurance. Is there any reason for the Federal Government to take away more earnings of young workers to pay the cost of hospital care for the 9 million aged who already have insured themselves?

Proponents of King-Anderson, of course, have promoted the false idea that many, many older people are in need of medical care, and either cannot get it or supposedly are too proud to seek it. Yet three months ago I wrote to every congressman and senator asking for the names of specific individuals over 65 who could not receive health care because of inability to pay. If a real health care crisis exists among the aged as King-Anderson proponents contend, how come I have not yet received a single name? The medical profession has guaranteed medical care to everyone regardless of his ability to pay. And this includes both the young and the old. For years we have stood back of this pledge, and we will continue to do so.

We sincerely recognize that there is real need for financing hospital care for some older people. Our profession's record of supplying millions of dollars worth of free care to older people annually, and our profession's full support and promotion of the Kerr-Mills Law to help those who need help are convincing testimonials to our interest and concern for all these older people in need. And for those who can take care of themselves we are firmly convinced that the voluntary health insurance industry *can, does* and *will* provide the necessary policies to cover these people against the financial hardships of costly illness. We have favored and supported all such plans to protect the aged. We oppose those government proposals like the King-Anderson bill which destroy the phenomenal growth of health insurance among the aged.

HIGH TAX COSTS

Until now the Social Security has been a program of cash benefits for eligible beneficiaries. It must not now be changed to introduce a system of service benefits which are purchased and operated by the Federal Government from Washington with tax dollars. These taxes already are taking a sizable portion from wage earners' paychecks and from employers' income. Now the King-Anderson proponents would take even more from both sources.

Those who are saying that the bill would only cost the worker a nickel a day or a dollar a month *are not telling the truth.* The King-Anderson bill proposes to levy a quarter of one per cent on incomes up to $5,200. Yes, this *is* a tax increase of $13, but they conveniently forget that the bill raises the tax base from the present $4,800 to $5,200. And my arithmetic tells me that if you multiply this increase of $400 by the current tax rate of 3⅛ per cent, you come up with another $12.50. This then is a total tax raise of $25.50, or twice the amount that the King-Anderson proponents are willing to talk about. Furthermore, the employer pays another $25.50 on each employee. And everyone here knows that if the employer's taxes go up, he is going to raise prices to make ends meet. In the long run it will be the wage earners who are going to pay their own $25.50 plus the cost of inflation resulting from any King-Anderson bill.

I need not remind you that every new Federal tax imposed limits more strictly the potential tax resources of the State of Hawaii, every other state government, and all local governments. This combined new tax of $51 annually is only the beginning, too. Suppose the cost of King-Anderson

were double the HEW estimate, as several insurance actuaries have said it would be. Whether the *tax base* or the *tax rate* were raised to meet these higher costs, the effect would be the same: more and more taxes from wage earners and employers to pay for medical care for millions who can take care of themselves.

COVERAGE INADEQUATE

With the Social Security tax rate already scheduled to go to 4½ per cent each for employee and employer by 1968, and with future increases if King-Anderson were to become law, perhaps this nation would not be far from the vision of Mr. Wilbur Cohen, Assistant Secretary of HEW, who has testified that Social Security ultimately would require a 20 per cent total tax on employees and employers on a taxable wage base of $9,000.

Older people also have been led to believe that the King-Anderson bill would cover most, or all, of their medical care expenses. This is *totally false*. Last month Rep. Tom Curtis of Missouri said in the *Congressional Record* that the bill would cover less than 25 per cent of the medical expenditures of persons 65 and over. Are the King-Anderson proponents purposely ignoring this fact? I would think so. Apparently their only concern is to get their foot in the door and then go from there expanding the medical care benefits and, of course, raising the tax bite on wage earners and employers.

Of course, proponents of the bill don't talk about expansion—at least not now before they have established the "service concept" within the Social Security system. However, there is ample evidence to show that these kinds of programs do expand—in a quick and skyrocketing fashion. For example, in 1956 the disability amendment was passed allowing persons age 50 and over to start drawing old age benefits if they became "permanently and totally disabled." A few years later the age 50 requirement was completely eliminated. This was the first step. At first the projected total disability amendments were to amount to 318 million dollars by 1962. Well, here we are in 1962 and now the projected total cost is 935 million dollars, or three times the original. Now it also is estimated that by 1965 these payments will be running 1 billion 163 million dollars!

INEVITABLE EXPANSION

Yes, those who support the King-Anderson bill refuse to talk about possible future expansions, but we insist that *now* is the time to talk about them. The proposed legislation would establish the "service benefit" principle in the Social Security system, and we say that the American people must be told honestly now, *not later,* where this new principle will take them and their paychecks.

In the 1930's when the Social Security Act of "cash benefits" was proposed, the people were told that the Act would start with a 1 per cent tax each on employee and employer on wages up to $3,000. They were told that the percentage would rise through the years to a permanent level of 6 per cent—3 per cent for employee and 3 per cent for employers—by 1949.

While Social Security proponents then underestimated the cost somewhat—because the wage base is now $4,800 and the tax rate will go to 4½ per cent by 1968, at least they told the American people what to expect in the way of future payroll taxes under the system. Why shouldn't the American people now be told what this new principle of "service benefits" of limited or 25 per cent medical care for the aged, regardless of need or want, will cost immediately and in the future?

The American people are entitled to know what the future cost of expansion of benefits will be.

If there is anyone who doubts that the bill will be expanded or that it will cost more in future years, he need only return to the old Forand bill of proposed benefits. That bill offered more benefits than King-Anderson and it did not have a $20 to $90 payment from each hospitalized beneficiary as does the King-Anderson bill.

The same proponents of the old Forand bill now are supporting the King-Anderson bill, including Mr. Forand, who is heading up the National Council of Senior Citizens. They are the same ones who favored broader benefits a few years ago. Is there any reason then to assume that once the King-Anderson bill were to pass, they would not immediately propose more medical care benefits for the 14¼ million aged? I think not.

I am firmly convinced that passage of this bill would be the first major, irreversible step toward complete government medicine in the United States.

I remind you that only two moves would be required to achieve this. The first would be the provision of full medical care for the aged, including all physician's services. The second would be the elimination of all age restrictions. For the many reasons I have cited, and for many more which I do not have time to discuss, this legislation is a bad and dangerous proposal.

To defeat this measure all of us have a tough job ahead of us. Our foes are formidable. However, our support is growing as the Gallup Poll indicates, and it should continue to grow as we get our story to the American people. We must see that *reason,* not emotion and confusion, prevails in the decision by the people and by Congress on this issue. •

Presidential Address

J. A. BURDEN, M.D., *Haliimaile*

IT HAS always been the custom for the outgoing president to make a presidential address and to limit the incoming president to a "few remarks." It seems to me that it would be far more logical to limit the outgoing president to a "few remarks" and allow the incoming president to make the main address. After all, tomorrow I will be out of office and nothing I might say will have much influence, but the incoming president has been observing and laying his plans during the past year, and what better time is there for him to present his plans than at this annual convention at which he assumes office?

Another reason for eliminating the presidential address is the fact that usually very few people show up for it, the majority of the audience showing up just in time for the scientific speaker. The last time this convention was held on Maui, I think 17 persons showed up for the presidential address.

I am really flattered at the turnout tonight, but that can probably be attributed to the well planned program and the lack of private parties, making you, as it were, a captive audience.

Another tradition is that the president winds up his address by thanking all his officers, committee chairmen, and committee members for their support. I want to take the liberty of altering this custom by taking time out right now to do this for I think that will probably be the most important part of my speech. My officers and members of the Council have been wonderful to work with and have given me their wholehearted support. For this I thank them sincerely. I have been most fortunate in my appointments of committee chairmen. All of my committees have functioned well. Some of necessity have been more active than others but all have done good work. I would like to mention each committee by name but the list is long and my time is short. However, I do wish to give special mention to the Legislative Committee, the Public Relations Committee, the Emergency Medical Service Committee, and the newly-formed Medical Care Plans and Fees Committee. These committees have been especially active and I wish to commend all those who served so faithfully on them. I am afraid that most of us do not realize how much time and effort is expended by the members on these committees and how much the sacrifice made by these few means to the entire membership.

And lastly, I wish to express my deepest thanks to your incoming President, Fred Giles. He has been my right hand throughout the past year, attending the committee meetings I could not attend and performing all those functions I could not perform because of my distance from Honolulu. Without his help and counsel, I do not know what I would have done. I really think, Fred, that you are having a two-year term of office, but I do feel that the way you have pitched in and helped has thoroughly prepared you for the coming year so that I am certain it will be an outstanding one.

If anything I might say this evening will help to dispel the apparent apathy which seems to grip many of our doctors, I will deem it worthwhile. I have been amazed, as I visited the various county societies, how few knew anything about or were even conscious of the seriousness of the situation which now confronts us; the implications of the King-Anderson bill and the threat of socialization. More than once I heard remarks like "These changes aren't going to bother me, my practice is well established; let the young fellows worry about it," or "Well, socialization is coming eventually, so why fight it." It astounds me that some doctors have so little appreciation of their freedoms and their right to practice medicine as they see fit, that they are willing to surrender these freedoms without a fight, or for a handout from the government.

This apathy is also expressed in the attendance at the annual meeting. It is understandable that the percentage of doctors attending a meeting on an outside island, as this year, is small; but last year there was an outstanding scientific program and the sessions were arranged to accommodate the practicing physicians so as to interfere with their practice as little as possible, and yet less than one-third of the membership registered for the session. I am proud to state that registration of Maui doctors at this session is 95%.

Delivered at the 106th Annual Meeting of the Hawaii Medical Association, May 6, 1962.

This lack of interest is most unfortunate. I do not know whether it is because everyone is too busy practicing medicine to take an interest in other things, or because of a lack of confidence in our organization, but in either case it is a serious situation, for never before has the necessity for presenting a united front been greater, never before has the danger of socialization been more imminent, than it is today. Currently, the King-Anderson bill is pigeonholed in the House Ways and Means Committee, headed by Senator Wilbur Mills, who is strongly opposed to the bill. Three months ago the bill was kept in committee by a majority of five votes. Today, it is kept in committee by the slim margin of one vote, and the Administration is working hard to change that.

Whether the Administration is successful in passing the King-Anderson bill or not, the problem of medical care of the aged is going to be one of the major issues in the elections this fall. We all agree that the only logical answer to socialized medicine under government control is through voluntary insurance programs. I have yet to find a doctor who does not agree with this, except those few who favor socialized medicine. In view of this, it is hard for me to understand how any group of physicians can openly oppose and fight the one nonprofit insurance organization which has done more towards providing good prepaid medical care than all the commercial insurance carriers combined. Neither can I understand how a group of leaders in our organization can castigate and blackball fellow members because they have the guts and honesty to speak out for the good points of this organization, and then turn around and give a standing ovation to another member who has been openly and contemptuously "milking" the plan for his own benefit.

It is irresponsible, emotional actions like these that give medicine a black eye and give our opponents the ammunition they need to win their cause, and don't think for a minute, gentlemen, that they won't use every possible weapon to attain their objective of gaining control of the medical profession. Ex-Representative Forand, father of the Forand Bill for socializing medicine, recently stated that if the Administration is able to get the King-Anderson bill passed, they will have gotten a foot within the door and in the future will be able to expand the bill until it includes everyone. Many of us in Hawaii feel that the King-Anderson bill is no concern of ours for we already have an outstanding program for medical care for the aged through indigent and medical indigent care. That does not justify our doing nothing, for if the bill passes, it will be national in scope and we will have it whether we like it or not.

Only by united action by every state and by every doctor in these states, to present these problems to the public, your patients and my patients, explaining the reasons for our stand and enlisting their support, can we effectively defeat this bill.

You may have noted in a recent issue of the *Advertiser* an announcement regarding the platform for the Democratic party in Hawaii for the elections this fall. One paragraph of this platform pledges support to the plan for providing medical care for the aged through Social Security and also support for federal aid to education, both highly socializing programs, and yet you would be surprised at the number of times I have heard people say, "I think our schools should have federal support but the government has no business trying to socialize the doctors." I imagine that if we were listening to a group of educators we might hear something like this: "I think the plan to provide medical care through Social Security is wonderful. I have a hard time meeting my doctor bills and after all I have to pay Social Security taxes so I might as well get something for it. But I sure hope the Government stays out of education. Why, if the Government starts financing our schools, the next thing you know they will be telling us how to run them."

Our Legislative Committee did a wonderful job this past year. I am glad to see that you have approved their program for the coming year; however, we cannot let the activities of this committee lapse until the next session of the Legislature for there is much work to be done. It is not enough to defeat bad legislation. We must actively work to elect conservative candidates who are opposed to this socializing trend as well as actively try to defeat candidates who are in favor of it. We must not limit our efforts to medical matters alone, but we must take an active part in fighting government encroachment into every area of free enterprise. There is no better way for us to do this than by joining the Hawaii Physicians' League for Good Government, and actively working through it and through our local precinct clubs. If we will do this, we soon will not have to worry about our "public image," for we will be accepted as part of the public, and this is the way it should be.

I would like to close by quoting a statement made by a very well-known person—Nikita Khrushchev. He said, "We cannot expect the Americans to jump from capitalism to communism, but we can assist their elected leaders in giving Americans small doses of socialism, until they suddenly awake to find they have communism." On every hand we can see that this program of socialization is being urged. Gentlemen, it is time for us to stand up and be counted. •

Electromyography is a vital new tool for the investigation of neuropathies.

Electromyograpy and Electrical Stimulation:

A Brief Survey of Clinical Uses

MICHAEL M. OKIHIRO, M.D.,* *Honolulu*

• *Electromyography and electrical stimulation of nerves not only help determine the presence of disease of the motor unit, but also whether this affects primarily the anterior horn cell, the axon, the neuromuscular junction or the muscle fiber. Furthermore, they can be of value in the prognosis and the management of patients with neuromuscular disorders.*

ELECTROMYOGRAPHY and electrical stimulation of nerves have proved to be of great value in the investigation and understanding of neurologic phenomena and neurologic disorders, and have been assuming ever greater importance in clinical practice.

These two procedures of electrodiagnosis are often used together, and recently several commercial electromyographs have become available with which both of these procedures can be performed. A brief survey of the areas in which these two procedures of electrodiagnosis have proven to be of value is presented here.

ELECTRICAL STIMULATION OF NERVES

Nerve conduction studies are performed by applying stimulating electrodes on the skin over the nerves and recording the muscle action potential from an appropriate muscle.[1] A brief supramaximal electrical stimulus is applied, once to produce a single twitch, or repetitively to produce a tetanic contraction. The muscle action potential is amplified and recorded on a cathode ray oscilloscope from which photographic records are made.

POLYNEUROPATHIES

This study is of value in the diagnosis of the polyneuropathies, such as the chronic polyneuropathy of children, neuronitis (Guillain-Barré syndrome) and Charcot-Marie-Tooth disease. In all of these entities, there is slowing of motor nerve conduction, usually well below the normal range of 45 to 70 meters per second. A minimal to moderate slowing of conduction is often seen in diabetic neuropathy.[2] In some cases of peripheral neuropathies where the manifestations are primarily sensory, motor nerve conduction may be normal.

MONONEUROPATHIES

In the mononeuropathies, whether the lesion is due to trauma, tumor, or other causes, nerve conduction studies are very helpful not only in defining the lesion but also in localizing it. One often sees mononeuropathies in which denervation has not yet occurred, but in which a functional block of nerve conduction is present (neuropraxia). Stimulation of the nerve proximal to the lesion may show slowing of conduction and a low voltage muscle action potential due to temporal dispersion of the motor fibers, whereas stimulation just distal

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to the site of block may show a normal conduction time and normal amplitude of action potential. Thus, nerve conduction studies are often helpful in defining such entities as tardy ulnar palsy and crossed-leg (or peroneal) palsy.

One of the areas in which nerve conduction studies have been of greatest aid has been in the diagnosis and definition of the carpal tunnel syndrome.[3] Most of these patients have uncomfortable paresthesias in their hands and fingers for many years before denervation and thenar atrophy occur. Yet often quite early in the course of the disease there is prolongation of the latency of response of the median nerve between the wrist and the thenar muscles.

If a nerve has been acutely injured, evidence of progressive inexcitability of the nerve and subsequent recovery of function can be detected by periodic tests. Such information is often of prognostic value and may help to decide whether or not surgical intervention is indicated.

MYASTHENIC SYNDROMES

Another area in which nerve conduction studies have found use is in the diagnosis of myasthenia gravis and other myasthenic syndromes.[4] These patients show a progressive decline in the amplitude of the muscle action potential on repetitive stimulation of the nerve at rates of about three per second. This phenomenon is called the myasthenic or Jolly reaction after the man who discovered it; the same man named the disease, myasthenia gravis. The injection of anticholinesterase drugs, such as Tensilon or prostigmin, will tend to reverse the defect of neuromuscular transmission both clinically and electrically.

NEEDLE ELECTROMYOGRAPHY

The classical electromyographic examination consists of recording the variations of electrical potential recorded by a needle electrode inserted into a skeletal muscle.[1] The electrical activity is amplified and displayed on a cathode ray oscilloscope and at the same time is displayed over a loudspeaker for simultaneous visual and auditory analysis. Observations are made on insertion or movement of the needle, while the muscle is at rest, and during voluntary contraction of the muscle.

Before going on further, a few terms should be defined. The motor unit is defined as the lower motor neuron and all of the muscle fibers that it innervates, and thus includes the axon and neuromuscular junctions.

Fasciculation is the common type of muscle twitch which is clinically observable in resting muscles and represents the spontaneous contraction of the muscle fibers of a single motor unit. By themselves, fasciculations are not evidence of denervation or disease, and may be found in otherwise normal persons. Classically, however, they are usually associated with diseases affecting the anterior horn cells.

Fibrillation is the spontaneous activity of a single muscle fiber. It is not visible through the skin and is identified by its electrical activity as a small electrical potential, 25 to 250 microvolts in amplitude, and is regularly seen in denervated muscles.

Let us now take the various groups of disease entities of the motor unit and discuss the types of electromyographic findings which are usually found. However, before going on further it is well to note that at times "paralysis," muscle weakness, and muscle atrophy may be attributed solely to pain, hysterical or conversion mechanisms, malingering or disuse, and these conditions may be very difficult to distinguish clinically from disease of the motor unit. In such situations, the lack of definite defects of the motor unit on electromyographic studies may be of utmost diagnostic importance.

ANTERIOR HORN CELL DISEASES

In diseases of the anterior horn cells such as poliomyelitis, the progressive muscular atrophies, including Werdnig-Hoffmann disease, and amyotrophic lateral sclerosis, there is usually evidence of denervation (fibrillation), fasciculations, and motor units which are decreased in number but which tend to be large. The exact reason for the latter is not known, although several theories have been proposed.[5] The findings are generalized rather than following any neuroanatomic pattern.

NERVE ROOT LESIONS

In nerve root lesions whether due to tumors, cervical discs, or cervical spondylosis, denervation follows and is confined to a specific nerve root. In addition, the motor units, which may be decreased in number, often tend to be slightly increased in size. The latter is not true, however, in root lesions due to lumbar discs, as here the lesion is usually quite distant from the anterior horn cell. It is well to recall here that in root lesions, denervation occurs in the paraspinal muscles supplied by the posterior primary division of the nerve root, as distinguished from lesions situated more peripherally out in the plexus or nerve.

PERIPHERAL NERVE LESIONS

In lesions affecting a plexus or peripheral nerve, the area of denervation again follows the specific anatomic pattern. Fasciculations are not usually

seen, and the motor units may be decreased in number but are of normal size.

MYASTHENIC SYNDROME

In myasthenia gravis and other myasthenic syndromes, variations in the size of a motor unit may be evident. In the normal muscle with the needle electrode adjacent to a single motor unit, the amplitude of the muscle action potential remains constant, but with defects of the neuromuscular junction, the size of the motor unit may vary from moment to moment.

PRIMARY MYOPATHIES

In the primary myopathies, weakness is associated with a decrease in size rather than a decrease in the number of motor units.[6] Motor unit potentials are of low amplitude and short duration, and are often increased in number relative to the strength of contraction. The potentials consist mainly of sharp spikes and polyphasic potentials. In addition, in polymyositis and dermatomyositis, there are usually some fibrillation potentials. But in the muscular dystrophies, fibrillation potentials are uncommon, although a few, short-duration, positive spikes are not infrequently present.

MYOTONIAS

In myotonia congenita and myotonic dystrophy a characteristic electromyographic pattern is seen. On insertion or movement of the needle, or with the slightest voluntary contraction, prolonged trains of spikes and positive waves with a characteristic waxing and waning quality are seen discharging at a high frequency. The sound which accompanies these discharges is also characteristic and has been likened to that of a dive bomber. ●

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English chemists are keeping penicillin in the forefront by improving on the original product, year after year.

Antibiotic Treatment of Staphylococcal Disease

D. E. TORIN, CAPTAIN, MC,* *Honolulu*

• *Staphylococci have become so generally resistant to ordinary natural penicillin, and other antistaphylococcal antibiotics are so often either ineffective or dangerous, that the new synthetic penicillins are currently the preferred antibiotics for serious staphylococcal disease. Methicillin (Staphcillin) is probably the best of these.*

THERE IS no satisfactory method of treating severe staphylococcal infection. Despite all available modalities of treatment, in severe infections such as pneumonia, endocarditis, meningitis, or septicemia, the death rate ranges as high as 45%.[26] Treatment has remained unsatisfactory largely because of the following factors:

1. In most series, the majority of severe staphylococcal infections strike already hospitalized patients. Therefore, most of these infections begin with an already weakened or debilitated host.
2. Since hospital organisms are constantly exposed to multiple antibiotics, and since the staphylococcal organism tends to develop resistance to each new drug in wide use, an infection acquired within a hospital is usually antibiotic resistant.
3. Staphylococci rapidly produce focal necrosis, so even at the onset of timely therapy suppuration already exists.
4. Staphylococci within abscesses are only minimally susceptible to antibiotics.
5. Even susceptible staphylococci are killed only slowly if they are within tissues.
6. Many clinical situations are so urgent that therapy must be attempted before sensitivity studies are completed. Therefore, the best available agent may not be the first one used.[19]

The staphylococcus has become a penicillin-resistant organism throughout the world. In 1945, in Great Britain, 20 per cent of staphylococci tested were resistant to small doses of penicillin.[25] By 1960, the figure had risen to 75 per cent.[24] It is reported that in New Zealand 90 per cent of hospital, and 50 per cent of "community" staphylococci are resistant to penicillin.[9] In Denmark, the comparable figures are 92 and 69 per cent,[6] in Boston, 86 and 73 per cent.[28]

* Tripler General Hospital.
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SAFE ANTIBIOTICS

Cumulative figures on staphylococcal resistance to other common antibiotics follow:

	HOSPITAL STRAINS PERCENTAGE RESISTANT	COMMUNITY STRAINS PERCENTAGE RESISTANT
Streptomycin	50-75	19-35
Tetracycline	20-51	6-19
Chloromycetin	2-14	0-2
Erythromycin	0-34	0-7
Novobiocin	0-11	0-2[1,6,9,28]

It is of interest to compare these figures with the resistance pattern of staphylococci obtained at autopsy from fatal cases of staphylococcal disease in Boston during 1959 and 1960.

ANTIBIOTIC	PERCENTAGE OF STAPHYLOCOCCI RESISTANT
Penicillin	89
Streptomycin	78
Tetracycline	76
Chloramphenicol	31
Erythromycin	66
Novobiocin	16[28]

The value of erythromycin in staphylococcal diseases is well documented. An added attraction is that it has remarkably few significant side effects. With a dosage of 1 gm per day, erythromycin can be expected to cause nausea, vomiting or diarrhea in less than 2 per cent of patients, while with 2 gm per day, the figure rises to 5 per cent. These side effects are often controllable with anti-

emetics. Fatal side effects are unknown. In severe infections up to 6 gm of erythromycin per day may be given intravenously with no significant ill effects.[1, 19]

Chloromycetin has a very low incidence of side effects, but unfortunately those that do occur are often serious. Fatal blood dyscrasias are the major cause of concern. Occasionally, organisms exhibit cross resistance to chloromycetin and erythromycin; however, this combination is often the first used against staphylococcal infections.[9, 19]

NOVOBIOCIN

Novobiocin, introduced as streptonivicin in 1955, occupies a place between the commonly used drugs and the more dangerous drugs to be discussed shortly. Novobiocin (Albamycin, Cathomycin) has to date been used sparingly and it remains effective against most staphylococci.[8] There is an incidence of side effects ranging from 6 to 41 per cent, mainly allergic dermatitis, drug fever, nausea, vomiting, and diarrhea. Occasionally, leukopenia is noted.[21] A yellow pigment, not bile, has been reportedly found in the serum of many patients during novobiocin treatment. Its significance is not well established.[17] Although usually administered orally in doses of 250 to 500 mg, q.i.d., novobiocin has in a few instances been given successfully by the intravenous route.[8] There is no cross resistance between novobiocin and erythromycin or Chloromycetin,[9] but there probably is cross resistance between novobiocin and vancomycin.[26]

DANGEROUS ANTIBIOTICS

During the last five years, three potent but dangerous antistaphylococcal drugs have become available—vancomycin, ristocetin, and kanamycin.

These drugs have been reserved for severe staphylococcal infections, usually under the following four circumstances:

1. The staphylococcus in question is resistant to all other available antibiotics.
2. There has been no response to other antibiotics.
3. The infection is so severe that therapy must be begun before sensitivity studies become available, and a wrong choice would be fatal.
4. Hypersensitivity precludes the use of otherwise suitable drugs.

Ristocetin (Spontin) was developed in 1956 at the Abbott Laboratories. All staphylococci are sensitive *in vitro* to this agent. It may only be administered intravenously, usually in doses of 500 to 1000 mg in 150 ml of 5% glucose in water every 6 hours. There is a 20 to 30 per cent incidence of side effects, and perhaps a 1 to 2 per cent incidence of death caused by the drug. Morbilliform rash, often with significant exfoliation, is the most common complication; but the more life-threatening complications are agranulocytosis, thrombocytopenia, and renal damage. Deafness has also been reported. The bone marrow depression develops gradually; irreversible damage can be forestalled by daily white blood cell and platelet counts.

Kanamycin, related to neomycin, was developed by Umezawa of Japan. Its spectrum is broad, but all staphylococci to date show *in vitro* sensitivity. The usual dosage is 500 mg, given intramuscularly every six hours. The over-all rate of side effects is not very high, about 10 to 15 per cent, but the reactions are usually severe. Permanent deafness and severe renal damage are the most serious problems. A slight rise in BUN is common and does not preclude further treatment, but a severe toxic nephrosis may occur in over five per cent of patients, and may prove fatal.

Vancomycin (Vancocin) was developed in 1956 at the Lilly Laboratories. As with kanamycin and ristocetin, all staphylococci are sensitive to this agent.[26] The dose administered is usually 500 mg every six hours intravenously in 150-200 ml of 5% glucose and water,[14, 26] but up to 2.5 grams daily has been used.[5] The incidence of side effects approaches 15 per cent. Nonexfoliative skin eruptions are the most common. Transient deafness has been reported. Severe renal damage has been reported occasionally, but a modest rise in BUN is usual and is not associated with severe renal damage. It has been advised that urinalyses, BUN determinations, urine output, and complete blood counts be closely monitored, but the exact point where further vancomycin therapy is contraindicated is uncertain.

In one controlled series where vancomycin, ristocetin, and kanamycin were alternated among severely ill patients, the survival rates were 59, 55, and 53 per cent respectively.[26] There are several reports that hint at the superiority of vancomycin because of therapeutic successes with this drug following failure of ristocetin and kanamycin despite *in vitro* sensitivity studies that showed the staphylococcus had been sensitive to all three agents.[5, 26]

In general, in overwhelming infections 14-20 days of treatment is necessary. Even then, despite improvement, viable staphylococci still sensitive to the potent agent used may be recovered.[14]

Before the topic of dangerous drugs is closed, bacitracin should be mentioned. This agent has been used little against staphylococcal infection in recent years, but remains a potent antistaphylococcal drug. It is bactericidal against most staphylococci. The dose used is up to 100,000 units a day intramuscularly, usually given at the rate of

10-20,000 units every eight hours. Because it is a polypeptide, the use of bacitracin is always followed by renal tubular swelling and albuminuria. The albumin excretion usually reaches a maximum on the fifth to seventh day of therapy and then may fall or remain stable. Often, granular casts and mild azotemia accompany the reaction. The incidence of severe renal damage is decreased by insuring adequate fluid intake and an alkaline urine. In the presence of an adequate fluid intake, if the urine output falls below 800 ml per day, permanent renal damage is imminent and bacitracin should be halted. Other side effects produced are not life-threatening and include nausea, vomiting, urticaria, and pyrexia.[16]

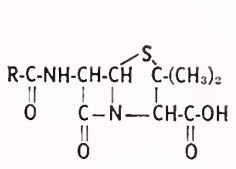
NEW PENICILLINS

The development of new synthetic penicillins during the last two years may revolutionize anti-staphylococcal therapy. It is too soon to fully define the role of these new drugs, but sufficient evidence of unusual efficacy exists to warrant great optimism.

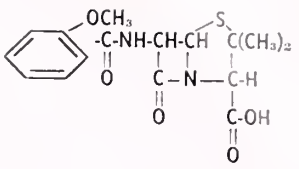
The production of 6-amino penicillanic acid in Great Britain opened the door to tailoring of the synthetic penicillin molecule.[27] The first of these new drugs to be given wide publicity and use was phenethicillin or phenoxyethyl penicillin (6-alpha-(phenoxypropionamido) penicillanate), known as "Syncillin" in the United States and penicillin B or "Broxil" in Great Britain. Early reports indicated that this drug offered great promise in the treatment of penicillin-resistant staphylococcal infections,[4] but further investigation has definitely shown that although phenethicillin is somewhat more active than natural penicillin against penicillinase-producers *in vitro*,[4,7,27] there is no significant advantage in clinical situations.[4] Therefore, phenethicillin "cannot . . . be recommended for use in the treatment of infections with resistant strains of staph. aureus."[7]

The false hopes concerning phenethicillin in late 1959 and early 1960 cast doubt on the usefulness of synthetically tailoring the penicillin molecule. However, the next product to enjoy glowing reports has to date been most impressive in actual clinical practice. This product was originally designated BRL 1241 and is described as 2,6-dimethoxyphenyl penicillin, or "Staphcillin" in the United States and as 2,6-dimethoxybenzamido penicillin, methicillin, BRL 1241, or "Celbenin" in Great Britain.[18,20,23]

Methicillin is a neutral solution stable for five days at 5° C.[18] It shares the properties of other penicillins as to their intramuscular-absorption patterns, lack of animal toxicity, poor crossing of the intact blood-brain barrier,[2] and competition with probenecid for excretion.[20]



Penicillin



Methicillin

Methicillin stimulates the production of staphylococcal penicillinase, but is not destroyed by this penicillinase. Thus, the activity of methicillin against staphylococci is totally independent of resistance to penicillin G, the highly resistant strains showing the same order of sensitivity as the penicillin-sensitive strains.[18] Figures reported are spectacular: of 1,118 pathogenic strains in one study, only 202 of which were susceptible to crystalline penicillin G, all 1,118 were susceptible to methicillin.[25] To date, one resistant strain has been reported out of thousands tested.[11] Bactericidal levels are only slightly above minimal inhibitory levels, and range from 1.25 to 12.5 micrograms per ml, with 98 per cent of the strains being inhibited by under 6 micrograms per ml, independent of the size of the inoculum.[12,18,20]

The question of whether resistance is likely to develop has been actively pursued. After incubation for 24 hours with penicillinase-producing organisms, methicillin's activity decreases 10 per cent. Bacteriocidal activity is never complete, approaching 99 per cent in four hours, and if cultures are allowed to remain for several days, slow growth will then begin. However, the penicillinase produced by these slowly-growing organisms is not altered, and is not more effective against methicillin.[22]

Studies *in vitro* make clear that methicillin is not just another penicillin that is "immune" to penicillinase. Puzzling and as yet unexplained is the fact that Staph. albus can develop significant resistance to methicillin, both *in vivo* and *in vitro*.[23] Group D, beta-hemolytic streptococci are more resistant to methicillin than to penicillin G,[22] as are Neisseria meningitidis and non–penicillin-resistant Staphylococcus aureus.[12] There are suggestions that methicillin is less effective against Group A beta hemolytic streptococci also.[24]

In clinical use, 1-1.5 gm are given intramuscularly every four to six hours. Blood levels reported after 1 gm intramuscular injections are:

½ hour	17-20	micrograms/ml
1 hour	7.3-20	"
2 hours	5-9	"
3 hours	1.5-2.7	"
4 hours	1-3.8	"
6 hours	0-0.5	" [3,13,20]

In children, 100 mg/kg/day has been suggested as producing similar blood levels.[22,24]

Reports of methicillin's clinical activity have been glowing. Douthwaite and Trafford report 13 of 13 patients cured of staphylococcal pneumonia;[3] Stewart *et al.* speak of 17 cases, all of whom improved, and of 16 in whom the staphylococcus was eliminated.[24] Ruternburg *et al.* from Boston, report 41 patients with staphylococcal infections, 31 of whom had failed to respond to other antibiotics, and state that there was elimination of the staphylococcus in all 41 cases.[20] Allergic reactions to methicillin, identical with those to other penicillins, have occurred.[3, 22] Intramuscular injections are quite painful and local reactions may occur about the site of injection.[3]

To quote from Stewart in the *British Medical Journal,* "It is obviously impossible at the present stage (September, 1960) to define the full therapeutic role of BRL 1241 (methicillin) . . . it is reasonable to conclude that the compound has a high and unusually consistent degree of activity against staphylococci."[22] And to quote from Wellmark and Finland in the *Proceedings of the Society for Experimental Biology and Medicine* of January, 1961, "[methicillin is] certainly not the drug of choice against infections with non–penicillinase-producing staphylococci."[27]

The direction new developments in synthetic penicillins may take is indicated by the development of penicillin PA-248. This drug, alpha-phenoxylpropyl penicillin, is well absorbed orally, producing blood levels three to four times that of penicillin V with comparable oral dosages.[29] It is reported to be 2-16 times as lethal as penicillin G for moderately penicillin-resistant staphylococci.[10]

One report of five cases of penicillin-resistant staphylococcal pneumonia, reported five cures with PA-248. Unfortunately, no mention is made of the degree of bacterial resistance.[15]

This particular drug does not appear to be sufficiently potent to be a useful anti-staphylococcal agent, but it may become the prototype of more efficacious oral penicillins.

SUMMARY

Staphylococcal infections are often difficult to treat because of host debility, and microbe resistance. Of the older and more commonly utilized antibiotics, erythromycin, chloromycetin, and novobiocin are the most frequently efficacious. Natural penicillins are effective against only a small minority of staphylococci.

Ristocetin, kanamycin, and vancomycin are highly effective antistaphylococcal agents, but their severe side effects limit their usefulness. Of the three, vancomycin may be the best. Bacitracin remains useful, but dangerous.

New synthetic penicillins, developed in Great Britain, offer great promise in the therapy of staphylococcal infection. Methicillin ("Staphcillin," "BRL 1241," "Celbenin," 2,6-dimethoxyphenyl penicillin, 2,6-dimethoxybenzamido penicillin) has proven the most useful of the new drugs.

Research designed to further tailor the basic penicillin molecule continues and an oral synthetic penicillin, PA-248, while probably not clinically useful, may be the prototype for effective oral antistaphylococcal synthetic penicillin. ●

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Primary Hyperthyroidism

A Symposium

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THIS SYMPOSIUM was presented on Tuesday, September 26, 1961, at Queen's Hospital by members of the Surgical House Staff.

The Diagnosis of Primary Hyperthyroidism

DR. STEPHEN SCHWARTZ

The diagnosis of primary hyperthyroidism rests on a combination of clinical findings and laboratory studies. In the average case, the diagnosis can be made on clinical evidence alone and very rapidly confirmed in the laboratory; in a problem case, a wide range of laboratory tests is available.

CLINICAL FEATURES

Clinically, in the classical case, the body as a whole has a sensation of warmth; there are increased sweating and a warm, moist skin, particularly of the palms; increased appetite; and despite that, weight loss.

Cardiovascular findings include tachycardia, auricular fibrillation, congestive failure refractory to diuretics and to digitalis, high pulse pressure, increased cardiac irritability, increased cardiac output, precordial pain, angina, polyuria, and increased blood volume.

Muscular system findings are myasthenia, muscle atrophy, increased urinary creatinine, and increased amplitude of the electrocardiogram.

Nervous system findings include tremor, palpitations, nausea, vomiting, diarrhea, abdominal pain, overactivity, increased irritability and active cerebration often extending to a level of psychosis.

Other manifestations are increased sexual activity, oligomenorrhea or amenorrhea, increased sensitivity to epinephrine, and, of course, ophthalmic manifestations including retraction of the upper eyelids (due to increased sensitivity of smooth muscle cells to epinephrine), lid-lag, nonpitting fullness of the upper lids, injection particularly in the temporal part of the globe, limitation of upward and then lateral gaze, and chemosis.

As previously mentioned, most cases of hyperthyroidism can be, and in the past were, diagnosed purely on clinical findings. However, several laboratory tests are available to help diagnose an early case, an incipient case, or a masked case of hyperthyroidism.

CLEARANCE TESTS

I shall first discuss three clearance tests which are available but very rarely used: The thyroidal

plasma clearance test, the renal clearance of I^{131} radioactive iodine, and the salivary clearance of I^{131}.

In the thyroidal plasma clearance test, a measured dose of I^{131} is administered and later a sample of plasma is analyzed for I^{131} content. The following equation gives milliliters of plasma cleared per minute:

$$\text{milliliters cleared per minute} = \frac{\text{Thyroid } I^{131} \text{ concentration at time n}}{(\text{plasma iodide}^{131} \text{ concentration})\ (\text{n in min.})}$$

In the renal clearance test, a euthyroid patient is able to put out 35-65 per cent of an administered dose of I^{131} over a 24-hour period, whereas the hyperthyroid patient usually puts out less than 35 per cent of the dose, the rest being retained in the thyroid gland itself. The reliability of this test presupposes normal renal function.

In the salivary clearance test of I^{131}, a 2 cc aliquot of saliva is analyzed for I^{131} content at 24 hours.

OTHER TESTS

One of the more commonly used tests is the I^{131} thyroid uptake at 24 hours, in which a measured dose of I^{131} is administered, and at 24 hours the thyroid gland scanned for radioactivity. Euthyroid individuals have uptake of as much as 45 per cent, hyperthyroids usually greater than 45 per cent.

The protein bound iodine test is available in two forms: The routine P.B.I. and also PBI^{131}, the PBI^{131} being a more specific test not influenced by exogenous iodine intake. Another aspect of the PBI^{131} test is its use in determining the conversion ratio of the gland and relating plasma clearance to thyroid synthesis and release. The euthyroid patient usually has less than 0.3 factor turnover, whereas the hyperthyroid patient has 0.35 or higher.

Butanol-extractable iodine, a variant of the PBI type of test, eliminates many exogenous iodine artifacts. In the normal individual, the butanol-extractable portion exceeds 65 per cent of the PBI value.

Basal metabolic rate, one of the earliest and most widely used of all the tests, has to some extent fallen into disrepute. Most articles on the subject state that the BMR is probably one of the best tests available if properly administered, but due to the many artifacts and errors possible in administering the test, it is quite frequently inaccurate.

A relatively new test is the red blood cell binding of I^{131}-labeled tri-iodothyronine. This is based on the principle that the plasma has certain binding sites for iodine protein moieties and that in the hyperthyroid these sites are all filled so that there is overflow into the red blood cell. Thus a hyperthyroid patient has a 22-23 per cent uptake, whereas the euthyroid patient has a 13-15 per cent uptake. Exogenous iodide and organic-bound nonhormonal iodine do not appreciably alter the observed levels of red cell binding in this test.

A test which has found considerable favor with members of the medical staff at The Queen's Hospital is the suppression test of the thyroid gland. Tri-iodothyronine given for seven days, 25 mcg t.i.d., will block the normal 24-hour uptake, but will not depress uptake in the hyperthyroid below 20 per cent. This is the basis of the Werner test.

Whieh test is best? Kaplan[1] in 1959, reviewing thyroid function stated:

> For an over-all screening procedure we prefer a clinical evaluation, plus 24-hour I^{131} uptake, I^{131} conversion ratio, and a protein bound iodine determination. With such a broad approach a reasonable evaluation of thyroid function can be made in most instances.
>
> The clinician must always bear in mind that the function of the thyroid gland has many facets, and a profile of the function is superior to any single test procedure.

Surgical vs. Medical Treatment of Primary Hyperthyroidism

DR. JOHN AMBROSE

First of all, I want to mention some general principles that I have run across. I want to point out that there is no real agreement on what method should be used, and there is a great deal of room for personal prejudice in treating this disease. Also, I want to point out that this is a cyclic type of disease in that it may undergo spontaneous remission. This can be seen in some cases, especially in the adolescent variety where the disease will recede after adolescence.

The most specific form of treatment seems to be to destroy the tissue of the gland by surgery or by radio-iodine, and this seems to hold true as a general principle in treating this disease. Under the medical measures, first of all, radio-iodine is generally held to be the treatment of choice in a person over 40 years of age with Graves' disease. Now, I am not speaking of a nodular condition. Recurrent thyrotoxicosis following surgery is also treated this way, as are people who refuse surgery, or those uncooperative, such as psychotic patients.

USE OF RADIO-IODINE

Now, other contraindications to surgery are in the case of cardiac patients, and radio-iodine is found to be excellent for use in these patients.

Radio-iodine is contraindicated where the life expectancy is 25 years or more and also in pregnancy, where there may be damage to fetal thyroid. Radio-iodine has a disadvantage in that the same dosage, for example about 5 millicuries, may produce either no effect, or myxedema, or an exacerbation of hyperthyroidism and so the dosage is unsettled as to what should be used. When we have good results we may have 95 per cent sucess with the first three doses. There is a condition similar to thyroid storm following the use of radioactive iodine. There are cases of extreme resistance; one was reported requiring up to 117 millicuries, which is a huge dosage of radiation, in order to cure hyperthyroidism. Also, eye changes have been noted to progress under radio-iodine treatment, even appearing following its use. Tracheitis and thyroiditis are also reported, these conditions being rather rare, however.

Iodide is used in conjunction with the antithyroid drugs and rarely by itself. The antithyroid drugs are thiouracil and thiocyanate and the modifications thereof such as propylthiouracil. These are thought to be very useful in younger patients. Those who refuse surgery should have the antithyroid drugs as should those being prepared for surgery. Some people feel that in the last trimester of pregnancy antithyroid drugs can be used. There were some reports that this produced goiter in the fetus; I was unable to substantiate this, but Astwood did a series of his own and he found that no goiter occurred. Those cases which were reported were felt to be due to overdosage of antithyroid drugs. Rarely you may have hyperthyroidism of very short duration which will respond to antithyroid drugs and undergo remission in a short period of time under therapy. One disadvantage of the antithyroid drugs is that it takes up to two years to give a full course of treatment and one may have as much as 50 per cent recurrence. Other complications reported are agranulocytosis, fever, hepatocellular jaundice, serum sickness, dermatitis, pruritus, arthralgia, and some of the collagen diseases.

SURGICAL THYROIDECTOMY

Surgery is felt to be the treatment of choice, excluding the previous mentioned categories, for persons under 40. In a subtotal thyroidectomy there is a 90 per cent likelihood of relief after the first operation; if disease recurs, about 50 per cent following the second operation, and about 25 per cent after the third operation. This is apart from surgical complications which will be mentioned later. Surgery is used more specifically for toxic nodular goiters, Graves' disease, patients under 40, and for goiters so large they would require a dangerous quantity of radio-iodine; also, in the first trimester of pregnancy surgery is sometimes used. Briefly, surgical mortality is thought to be 0.2 per cent, which is the average of most series that I have run across; recurrence rate runs from 5 to 15 per cent.

Preoperative and Operative Management of Primary Hyperthyroidism

DR. JACK SCAFF

I have never done a subtotal thyroidectomy, but from my vantage point behind the left shoulder of the surgeon I have been able to see a number of subtotal thyroidectomies that I thought very closely matched the techniques that have been described in some of the reading I was able to do in the past week, and so I thought that in the next few minutes I might discuss some of the highlights that I have been able to observe and read about.

Assuming that the decision has been made that surgery offers an advantage over medical treatment and that the patient will have surgery, then the preoperative and operative program should be instituted so it will leave a euthyroid patient with as little morbidity as possible. Obviously before the patient goes to surgery he should be as euthyroid as possible for a number of reasons. He will approach surgery in a better frame of mind. The surgery itself will be safer, that is, there will probably be less bleeding, less anesthesia needed, there will be less chance for cardiac complications. Thyroid storm has rarely been reported postoperatively in a euthyroid patient undergoing a subtotal thyroidectomy. Hence, perhaps the only real treatment of thyroid storm is to prevent it.

PRE-OP DRUGS

A number of drugs, as Dr. Ambrose mentioned, are available for the preoperative management of Graves' disease. These fall into three classes of which the first is the antithyroid drugs themselves, such as tapazol, propylthiouracil, and iodothiouracil. These drugs, as you probably remember, block the conversion of the iodide ion to iodine in the gland and prevent it from being bound to other compounds. One thing that is interesting to note is that these drugs are administered in a dose four to six weeks in advance three times a day. However, the order should not be written t.i.d. but rather q.8.h. because of the degradation in the liver. Iodine is also of advantage in the preoperative management. It has been thought to perhaps inhibit the thyroid-stimulating hormone, but this has never really been proved. Rapid improve-

ment is noted; however, the patient breaks away rapidly, so it should not be used alone. It is perhaps a little better to use potassium iodide than Lugol's solution. In one reference I did find that Lugol's inactivated propylthiouracil and that these two drugs should not be used together. One advantage of iodine is that it will cause some involution of the gland, make it less vascular, and help prevent further hyperplasia that might occur when one of the antithyroid drugs is given alone.

Another drug that might be used is desiccated thyroid. It can prevent hypothyroidism if the antithyroid treatment is too vigorous. It can inhibit thyroid-stimulating hormone directly and perhaps prevent further exophthalmos, as it is thought that in Graves' disease, the exophthalmos is related directly to thyroid-stimulating hormone and not to the products of the thyroid gland itself.

SURGICAL COMPLICATIONS

Surgery of the thyroid is a rather complicated and extensive procedure. In no other incision that the general surgeon makes is the site of the incision more important, cosmetically. Perhaps it would be well to do indirect laryngoscopy in advance; if one found a paralyzed vocal cord on one side it might be better to reconsider whether surgery was the treatment of choice in this particular case. It has been shown that those surgeons who routinely divide the pretracheal muscles have fewer postoperative complications, such as, recurrent laryngeal nerve injury or parathyroid removal, than the surgeons who do not do this. It has also been shown that surgeons who routinely identify the recurrent laryngeal nerve have a slightly lower morbidity than those who do not. Many people use the term, "dissecting out the nerve." That is poor because it suggests trauma to the nerve, and often transient or permanent paralysis can result from bruising and edema. It is quite enough to identify the nerve during dissection, staying in the fascia and around the nerve without touching the nerve itself. An exposed nerve may be in danger of being entrapped in postoperative cicatrization.

PARATHYROID IDENTIFICATION

Parathyroid glands number four to six in a normal person, 87 per cent of people having four. Various criteria have been set up to identify parathyroids, but none hold up well; it is perhaps best that anything resembling a parathyroid, fatty lobule or not, be left behind.

The thyroid gland has a tremendous potency for regeneration; it has been shown that if more than 2 gm is left routinely, hypertrophy and recurrence of the disease may occur. If the isthmus or the pyramidal lobe is left, a small goiter may appear in the midline, causing a cosmetically poor result. I have tried to stay away from the post-operative complications as much as I could because Dr. Miyashiro will discuss these.

Postoperative Complications

DR. JAMES MIYASHIRO

Early postoperative complications: One of the most frequent early postoperative complications is hemorrhage. The incidence is approximately 2 per cent. The bleeding usually is not severe; however, in some instances there is much bleeding with respiratory distress from the hematoma pressing against the trachea. The treatment is obvious. Reoperation, control of bleeding, and sometimes emergency tracheotomy have to be done.

THYROID STORM

Another postoperative complication is thyroid storm or crisis. This is a most furious pathophysiologic state. Fortunately, it is rare since the advent of antithyroid drugs. The crisis usually appears after thyroidectomy in patients who are still actively hyperthyroid. In one series of 2,000 patients who were euthyroid prior to surgery, there was not one instance of crisis. The crisis can be seen also in patients who are hyperthyroid and who have a widespread infection, or in instances where the patient is hyperthyroid and undergoes some type of surgery other than thyroid surgery. The cause is still unknown. However, most authorities agree that thyroid storm is due to increased release of the thyroid hormone, perhaps because of manipulation of the gland during surgery, or some infectious process. One interesting thing is that it is never seen in patients with hyperthyroidism due to toxic nodular goiter but it is seen in those with toxic diffuse goiter. The symptoms to watch for are: (1) hyperthermia, (2) tachycardia, (3) wide pulse pressure, and (4) extreme restlessness. The patients usually progress through delirium, coma, diarrhea and pulmonary edema to death. From onset to termination is usually 36 to 48 hours. If the patient weathers this critical period, he has good chances of recovering. Mortality rate is still 75 per cent.

The first thing one wants to do is to give the patient a high dose of antithyroid drug, for example, propylthiouracil, 1,000 mg, followed by stable iodide. Next is antibiotic therapy. Hyperthermia is treated with an ice blanket, alcohol and sponge baths. The patient needs adequate fluids for rehydration.

The next complication is injury to the nerves. One nerve that is rarely injured is the superior laryngeal nerve. When this nerve is injured during surgery there is no danger to life. Symptoms are weakness of the voice and fatigue with phonation. With recurrent laryngeal nerve injury, frequently one can have some serious results. The incidence is 1 per cent; however, with repeat surgery the incidence goes up to 10 to 15 per cent. The first symptom is hoarseness. If only one side is injured, at times the injury is not discovered because the opposite cord may compensate adequately. Therefore, it is suggested that the larynx be examined routinely before and after thyroidectomy.

With bilateral paralysis the patient can suffocate. If the glottic passage is less than 4 mm, the result is that the patient will have good voice and cough reflex but the airway will be inadequate. Conversely, if the opening is greater than 7 mm, the patient will have good airway but the voice would be poor and the patient will have ineffective cough. The treatment for acute suffocation is tracheostomy. An operation has been reported in which the posterior extremity of the vocal process is removed. This gives a serviceable voice and improves the airway.

TETANY

Another postoperative complication is hypoparathyroidism. The incidence is 1 per cent. This is frequently seen with total thyroidectomy for cancer or with reoperation. The first symptom is tetany, appearing generally 24 hours or more after the operation. It is said that if the onset is shortly after the operation, this suggests the disturbance is permanent and will be progressive. However, if the onset is three to four days following surgery, it will be transient and will disappear. Other symptoms would be anxiousness, unpleasant sensations, and numbness or stiffness of the face, scalp, or extremities. The treatment is calcium gluconate by vein, one to two gm, slowly, for acute tetany. A high calcium–low phosphorous diet is prescribed. Parathyroid extract can be given; however, there is a rapid onset of refractiveness to the hormone. High doses of vitamin D, to promote absorption of both calcium and phosphorus, and A-T-10 have also been mentioned.

RECURRENCES AND MYXEDEMA

Two late postoperative complications are recurrent hyperthyroidism and hypothyroidism. There is 50 per cent failure for repeat surgery in recurrent hyperthyroidism. It is best therefore to treat it medically. The incidence of hypothyroidism is approximately 3.9 per cent, and the clinical picture is usually atypical. It is seldom evident earlier than one month after surgery. Treatment is desiccated thyroid. ●

REFERENCE

1. Kaplan, E.: Thyroid function. Med. Clin. North America, 43: 483-495, 1959.

(The panel is indebted to Mrs. Ena Hawkins and Mrs. Mae Soong for their assistance in the publication of this paper.)



The Presidents' Page



I have had the plcasure of a rather extensive mainland trip, attending meetings in Baltimore and Chicago. During this time I had the opportunity to call upon our Congressmen in Washington and to attend sessions of the House of Representatives and the Senatc of the United States Congress.

This experience gave me a good chance to talk to doctors from all sections of the mainland United States. It also gave me the opportunity to observe activitics of our representatives in Congress, both from Hawaii and from other states of our country.

One cannot help but form definite impressions from the contacts madc on such a trip. It is quite evident that the men of our profession are all highly aware of the dangers by which we are confronted today. These dangers arise from the desire of politically ambitious individuals to gain further powerful means of controlling the people of this country.

I must say that the doctors in our country are organizing in every possible way to overcome this threat. In Chicago, in speeches to the doctors, members of Congress strongly recommendcd that physicians should participate much more energetically in politics in the future than they have in the past, if they are to prescrve their freedom. We must strongly emphasize the fact that the medical profession, as a political entity, must work vigorously for political and social developments other than those which are directly associated with the interests of the practice of medicine. We as physicians must join our precinct clubs. We must participate in influencing voters to vote for men who will maintain the Constitution of the United States. It is necessary that we support thc man who wants a government which assumes its rightful placc, rather than one which attempts to become all powerful, leaving very little to thc states and subdivisions of government. The authority in government must be prevented from becoming concentrated in the hands of a few men in Washington.

This developing concentration of power is demonstrated at this time by attempts of President Kennedy to control industry, labor relations, medicine, agriculture, and foreign trade. These are the facts today which are causing great concern. The concern is that this authority will not be used for thc good of all; but that the rights of minorities and others will bc forgotten, the Constitution abrogated, and our rights disregarded and lost.

My visit with Senator Fong indicated to me that he is well informed in regard to the effect of the King-Anderson bill on our economy, on the standards of thc practice of medicine, and implications of this bill as far as the future of business and industry is concerned.

Representative Inouye is also well informed. However, he is in sympathy with the group of individuals that I have just described. This group appears to desire a greater centralization of power in Washington, and the control of medicine, agriculture, forcign trade, and other fields by government. In other words, he is hanging on to the coattails of President Kennedy.

Across the country there is great disillusionment with programs of this nature. The Madison Square rally backfired for Kennedy, and since that time there appears to be a swing against his programs. Congress is becoming disgruntled with the tactics and pressures exerted by President Kcnnedy and his advisors. I think we can say that the King-Anderson bill is dead at this time. The Administration sponsored amendmcnt introduced in the Senate was defeated by a vote of 52 to 48. However, the issue of health insurance paid for through Social Security is very much alive and will be an important factor in the November elections.

We must all get to work and insure that these individuals who will protect the ideals of America and the Constitution, and who will fight the development of socialism in our country, will be elected. We must activate our political action committees so that our organization can be more effective in helping our friends.



HAWAII MEDICAL JOURNAL

Editorials

The Service Concept and Social Security

The King-Anderson bill, HR 4222, suffers from many faults—it is misbranded as "health insurance" in its very title; it is wholly inadequate for those who need help, and covers many who don't; it is dictatorial and compulsory; and it would be outrageously expensive.

Serious as these are, they are trivial by comparison with its fundamental purpose, which—it is becoming increasingly obvious—is to tie the service concept into the Social Security system. The Administration has announced that it will accept any compromise, abandon any feature of the bill, just so long as this one aspect is retained.

- Former Representative Aimee Forand—who should know what is going on—has publicly stated that HR 4222 would be a "foot in the door."
- Nelson Cruickshank of the AFL-CIO said that "expanded benefits can come later. We don't have to go the whole way in one step."
- Secretary Abraham Ribicoff has said that he anticipates a Social Security tax of as much as 10% ("I don't think the American people will go for anything higher than that") and Wilbur Cohen, Assistant Secretary of HEW, said he thought it would go eventually to 20% on a tax base of $9,000.
- The Social Security Act has been amended—always by an increase of benefits and cost—in every election year since its inception over 30 years ago. It is inconceivable that anything less than national fiscal disaster will halt, or even slow, this trend. If HR 4222 passes—no matter how it may be restricted in its scope—we may confidently expect that America will go on and follow the path England has trod, to its cost, and that we will wind up with complete nationalization of medical practice.
- Hawaii State Representative Tom Gill told us last month that "if you object to full-scale socialization of medicine, then you have a valid basis for objecting to the King-Anderson bill."

Write to Dan Inouye and Senators Fong and Long, and get your friends, your neighbors, and your patients to do it! This is the year of decision. If this bill goes through, we will never get rid of it and we will never be able to stop it from making further inroads into our freedom to practice medicine as our judgment dictates. •

Glue Sniffing

Proteinuria, pyuria, erythrocyte stippling, a palpable liver, euphoria, disorientation, or mysterious somnolence may nowadays—if encountered in a teenage boy—be the result of toluene poisoning, caused by squirting plastic "airplane" cement into a paper napkin and inhaling the vapor.

The immediate effects of this practice may include dizziness, euphoria, visual and auditory hallucinations, or impulsive or destructive behavior. The practice, reports of which seem to have first appeared in Sweden five or six years ago, has been reported recently from five mainland states.

A wide variety of volatile organic solvents have been used in this way: ether, chloroform, methanol, petroleum ether and gasoline; in plastic cements, xylene, methyl isobutylketone, methyl cellosolve acetate, isopropyl alcohol, methylethyl ketone, acetone, or ethyl acetate, alone or in combinations. The commonest by far, in plastic cements, is toluene; and happily it appears to be one of the least dangerous of the lot.

At the moment, it seems unlikely that glue sniffing is common in Honolulu. In any event, it is generally of sociologic and toxicologic, rather than directly medical, significance. Physicians encountering instances of it are urged to obtain as detailed reports as possible—exact identity of the glue used, details of the "sniffing" indulged in, and all relevant clinical and laboratory observations, including EEG tracings and bone marrow studies if possible. These should be reported to the Department of Health or to Dr. Richard K. B. Ho of the Poison Control Center at Kauikeolani Children's Hospital. •

In Memoriam – Doctors of Hawaii

This is the thirty-ninth installment of In Memoriam—Doctors of Hawaii.

H. P. Hugus

Dr. H. P. Hugus, born about 1829, was a graduate of Jefferson Medical College at Philadelphia. He began his practice at Delmont, Pennsylvania, moved to Orrville, Ohio, and later settled in Los Angeles.

On July 6, 1889, Dr. and Mrs. Hugus arrived in Honolulu aboard the "Zealandia" from San Francisco and within a few days were on Kauai where the doctor had been appointed plantation physician for the Makee Sugar Company at Kealia. He also served as government physician for the district. After some three years on Kauai, Dr. Hugus left in December, 1892, to settle in California.

In September, 1893, the Board of Health had a letter from Dr. Hugus asking for a position as government physician. Since there were no openings at that time, his application was filed, and it wasn't until almost a year later that the Board offered him a position on Molokai (but not at the Leper Settlement). In replying from Ravenna, Ohio, the doctor refused this offer and requested an appointment to Koloa, Kauai. In November, 1895, there was a vacancy on Kauai, and this he accepted.

He returned to Honolulu on the "Australia" on January 5, 1896. Two days after his return, he was on his way to his old home at Kealia. He also resumed his former position as physician for the Makee Sugar Company. By 1899 the work of the district was so heavy that the Board of Health divided his district and sent Dr. French to cover the newly designated Hanalei district.

Dr. Hugus died July 31, 1900, at Kealia at the age of 61. He was survived by his wife.

The doctor was a charter member of the Knights of Pythias, Kealia Lodge No. 5, and held various offices in the organization.

Charles George Bull

Sometime in 1884 Dr. Charles G. Bull, an 1881 graduate of Bellevue Hospital Medical College, came to Honolulu. By early November he had a business card in the *Advertiser* giving his office location as the corner of Nuuanu and Kukui Streets. The following month he was called to Maui to attend Dr. Frank Enders in his final illness. Perhaps it was this trip that brought Maui to his attention as a possible site for a practice. In any event, early in 1885 he and Mrs. Bull moved to Makawao where the doctor established a practice. From 1886 to 1888 he served as government physician for the Makawao district. Of this appointment news notes from Maui reported that the appointment gave "general satisfaction" and added, "he is esteemed as a resident and liked as a professional man."

Plantation laborers, however, did not share the above sentiments for in August, 1885, the doctor was involved in charges of mistreatment of Japanese laborers at Paia Plantation. The trouble came to a head when, on the doctor's statement that three laborers who claimed they were sick and unable to work were fit to work, the manager had them taken before the magistrate. There on Dr. Bull's testimony that they were capable of working, they were fined $5 apiece and kept at Makawao for some days. They were then sent on foot to Wailuku (13 miles away) in charge of two native policemen. The trip took eight and a half hours under the hot sun and they were whipped and kicked along the way. On their arrival in Wailuku, the sheriff had Dr. Sutliff, the government physician there, examine the three. Dr. Sutliff found them very sick and sent them to the hospital where one of the three died. As a result of this death, an investigation was launched and when dissatisfaction with the medical care at Paia Plantation was general among the workers, all the Japanese were taken off the plantation and sent back to the Immigration Depot in Honolulu.

The doctor and his wife were active in church affairs. At one of the benefits to raise funds for the Catholic church being built at Paia, the doctor presented comical skits of Irish characters and sang.

After leaving Maui sometime in 1888, Dr. Bull settled on the mainland and became a well-known surgeon in Alameda, California. His death occurred at Greenville, California, on June 21, 1913, at the age of 54. ●

HAWAII MEDICAL JOURNAL

This Is What's New!

• A New York blood expert (Wiener) **critically attacks** many of the reeent reports which supposedly prove association between ABO and Rh-Hr **blood types** and **certain diseases.** He is very skeptical of "proved" association between such things as fractures of the femur and group "A", or duodenal ulcer and group "O". Further along in the same journal a London pediatrician, unaware of or undaunted by his New York colleague's skepticism, asks the reader to communicate to him the blood type of patients who develop generalized **vaccinia!** (*Lancet* [April 21] 1962.)

• Various diabetes detection drives carried out in Japan over the past few years indicate that the incidence of **diabetes** in Japan is about the same as in the United Staes. The detection drives in the United States indicated an incidence of one to two per cent. The **incidence in Japan** seems to jump very sharply in hypertensives with **nine per cent of hypertensives** over thc age of 40 being found to have diabetes. (*Diabetes* [Jan.-Feb.] 1962.)

• Approximately **three per cent** of patients with hyperthyroidism treated by **radioiodine** develop thyroid **nodules** several years after treatment. Biopsy of such nodules in eight patients reported from the University of California revealed no evidenee suggestive of malignancy savc for one single invasive adenoma. (*J. Clin. Endocrin. Metab.* [Jan.] 1962.)

• Two Navy medical officers discussed some contraindications to the use of life jackets for survival. As an alternative to "one hanging by his armpits in a watery field of gradient pressure," they suggest **inflatable rubberized suits** which were originally used by British Navy submariners for escape from disabled submarines. (*Arch. Environmental Health* [Jan.] 1962.)

• Prolonged administration of **salicylates** appears to produce **iron deficiency anemia.** In a careful study 11 subjects received three to four grams of aspirin a day; all had a drop in serum iron. This could not be explained by chemical interference, by blood loss, impaired absorption, or inereased excretion of iron. The survival time of red cells was diminished while the patients were receiving aspirin. The author suggests that salicylates might produce anemia not only by gastrointestinal **bleeding** but also by interference with metabolism of iron through some as yet **unknown mechanism.** (*Blood* [May] 1962.)

• Critchley of Queen Square, after spending more than a few years studying the **parietal lobes** of the brain, has been able to find no substitute for **careful clinical examination.** He demonstrates that the patient's parietal lobe deficiency is best defined by a penetrating history, as well as asking the patient to make little maps of his immediate vicinity, memory sketches of bicycles and clocks, and interpretation of **cartoons and drawings.** He finds the ability to recognize the meaning of a humorous drawing one of the most subtle tests of brain function. (*Medical Clinics of North America* [May] 1962.)

• Efforts to find safe blood-cholesterol-lowering agents continue. Two California investigators report the use of two dextroisomers of thyroid in lowering blood cholesterol–**dextrothyroxine** and **dextrotriiodothyronine.** On fairly large doses, slightly less than half of a small series treated with the two preparations had a **reduction of blood cholesterol** of **25 per cent or more.** Cardiac complications proved the greatest hazard, with several patients experiencing myocardial infarcts while on therapy. While further clinical trials are in order, it is already evident that neither of these preparations will be final answer to hypercholesteserolemia associated with coronary atherosclerosis. (*Ann. Int. Med.* [April] 1962.)

• In Minnesota 24 patients with **duodenal ulcers** have had their ulcers healed by actually **freezing the stomach.** The "physiological gastrectomy" is achieved by a coolant solution in a gastric balloon. (*J.A.M.A.* [May 12] 1962.)

• **Scanning for brain tumor** with **radioactive arsenic** proved to be a valuable diagnostic technique at the University of Toronto. Of several isotopes tried, arsenic 74 proved to be the most suitable. The diagnostic accuracy was less with low grade malignant gliomas than with the more malignant gliomas. (*Canadian Med. J.* quoted in *Worldwide Abstracts* [April] 1962.)

• From the Confederate Medical Museum in Richmond is reported a **100-year follow-up** of a **fractured radius** repaired with a **brass pin.** The pinned fracture was discovered by the use of a World War II mine detector over a mass Civil War battlefield grave. Although the brass pin had broken, the fracture had healed and the patient apparently died of later wounds. (*New Eng. J. Med.* [April 19] 1962.) •

FRED I. GILBERT, JR., M.D.



CARING FOR THE AGED

Medical Care for the aged seems to be the chief problem facing American medicine today.

Here in Hawaii HMSA has introduced a medical care plan for the Senior Citizens of our community. This plan, costing $9.82 per month per person, provides medical, surgical and hospital coverage.

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More than 5,000 residents of the State over 65 are already members of HMSA plans through either group or individual enrollment. Thousands more will be enrolling in the new "Plan 65."

The preservation of pre-paid medical service plans like HMSA depends on the whole-hearted cooperation of the members of the medical profession, and constitutes one of the strongest guarantees against encroachment by government medicine.

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HAWAII MEDICAL JOURNAL

Book Reviews

Early Detection and Diagnosis of Cancer

By Walter E. O'Donnell, M.D., Emerson Day, M.D., F.A.C.P., and Louis Venet, M.D., F.A.C.S., 286 pp., $12.00, The C. V. Mosby Company, 1962.

THIS BOOK has presented in a concise manner the clinical features of various cancers and the methods used in their detection and diagnosis. Techniques of tests are described along with comments as to their relative value. It is a good review and can be even used as a reference text.

Interestingly enough, although the three authors are staunch advocates of the concept and practice of "early" diagnosis and "early" treatment, they do concede that there are some cancers that appear to be completely influenced by the "biologic nature of the tumor" and unaffected by attempts at treatment. For the most part though, their belief that a substantial number of cancers can be cured by early treatment has prompted this writing.

WALTER Y. M. CHANG, M.D.

★General Pathology (3rd Ed.)

Edited by Sir Howard Florey, M.D., F.R.C.P., F.R.S., 1104 pp., $22.00, W. B. Saunders Company, 1962.

THIS TEXT should be owned by anyone interested in the distortion of structure and physiologic processes by disease and injury. The entire field is reviewed and knowledge gained from the use of new techniques is integrated with the major advances of the past. The text is lucid, the illustrations superb. The first edition appeared in 1954 and had 733 pages. The 1962 edition extends to 1104 pages. The illustrations of electron microscopy are particularly good and constitute an elementary course of instruction to those unfamiliar with this technique. They account for much of the increased bulk. Five chapters are now devoted to tumors, oncology being largely neglected in the first edition. Auto-immunity, which did not merit so much as an index reference in 1954, now is given three pages. Presumably later editions will give it one or more chapters. The 44 chapters are written by 17 authors, and all maintain a very high standard. For pathologists and pathology residents, this text is a necessity. Internists and physiology-minded surgeons will find it useful, and medical scholars will be charmed by its style.

GRANT N. STEMMERMANN, M.D.

A Workbook of Medical-Surgical Nursing

By Jean C. Barbata, R.N., B.S., Deborah M. Jensen, R.N., M.A., Marianna J. Koch, R.N., B.S., William G. Patterson, R.N., B.S., 374 pp., $4.95, C. P. Putnam's Sons, 1961.

THIS WORKBOOK can be used as a valuable teaching method for the professional student nurse. It integrates knowledge from allied health professions with nursing care. Although the approach is patient-centered, the major health problems, their prevention, pathology, diagnosis, treatment including pharmacologic and public health aspects, and frequently used terminology are adequately included.

The questions require some ability to make intelligent decisions; however, most of the information solicited may be obtained from textbooks. The workbook may serve the teacher as a tool in the construction of multiple choice test items and to further determine the student's ability to solve problems.

NOREEN T. MEINHART, R.N.

★ means highly recommended.

Carcinoma of the Cervix

By John B. Graham, M.D., Luciano S. J. Soto, M.D., and Frank P. Paloucek, M.D., 475 pp., $14.00, W. B. Saunders Company, 1962.

THIS FIRST edition monograph covers its subject from incidence and etiology through diagnosis and therapy to complications of the latter. Extensive discussion of radiation therapy is presented, with detailed charts, isodose curves, and illustrations of applicators used at various United States and European centers. Surgical treatment is also described in detail, with anatomical drawings and illustrations of apparatus for managing colostomies and ileostomies. A summary of the world experience with this disease, this book should be of value to surgeons, gynecologists, and radiotherapists, but most of all to women.

DORIS R. JASINSKI, M.D.

An Atlas of Head and Neck Surgery

By John M. Loré, Jr., M.D., F.A.C.S., 490 pp., $25.00, W. B. Saunders Company, 1962.

THIS ATLAS has presented a complete coverage of the many aspects of head and neck surgery. From radiographic anatomy to occlusive vascular disease, it has provided substance for the otolaryngologist, the plastic surgeon, the general surgeon, and of course the surgeon interested mainly in the head and neck areas. The illustrations are superb, the legends detailed, and the paper used of excellent quality. It compares very favorably with the volume by Dr. Hayes Martin and has only one detracting feature: expense ($25.00).

WALTER Y. M. CHANG, M.D.

★Textbook of Endocrinology (3rd Ed.)

Edited by Robert H. Williams, M.D., with contributions by Twenty-One Authorities, 1,204 pp., $21.00, W. B. Saunders Company, 1962.

THIS IS a remarkably lively textbook of endocrinology. Its editor has encouraged its excellent authors to "state their own opinions, even when tentative." The result of this policy is to get current ideas about the endocrine glands rapidly into the hands of the practitioners, rather than waiting until they are mellowed, thoroughly tested and superseded. The sections on the thyroid, the parathyroids, and the adrenals are outstanding, especially in newer diagnostic techniques. I know of no other textbook which brings the past up so soundly and looks into the future with such incision.

R. A. NORDYKE, M.D.

Also Received

British Medical Bulletin, Vol. 18, No. 2

F. T. G. Prunty, Scientific Editor, pp. 89-178, The British Council, May, 1962.

A REPORT of recent research on the adrenal cortex, plus reviews of books on this subject.

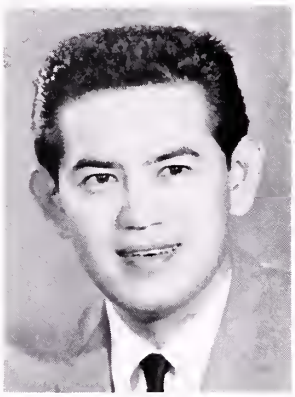
The Surgical Clinics of North America, Vol. 41, No. 5

Charles G. Child, III, M.D., Guest Editor, pp. 1141-1450, W. B. Saunders Co., October, 1961.

A SYMPOSIUM on problems of surgical management presented by the surgical faculty of the University of Michigan.

continued page 560

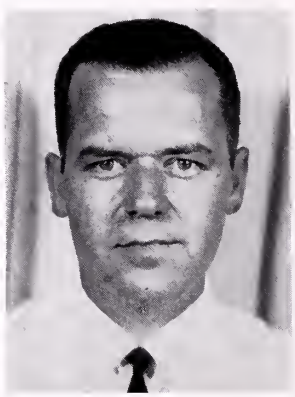
New Members



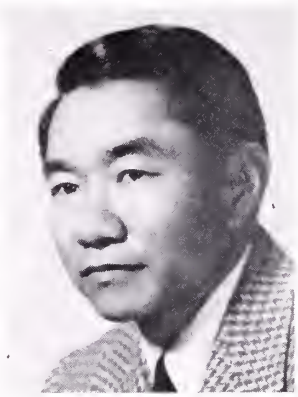
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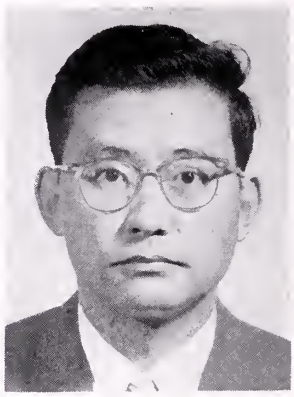
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Neurological Surgery
University of Oregon Medical School, 1954
Internship—Sacred Heart General Hospital
Residency—Good Samaritan Hospital, Portland, Oregon



Carl M. Mirikitani, M.D.
1010 S. King Street
Honolulu, Hawaii
Otolaryngology
Marquette University, 1940
Internship—W. A. Foote Memorial Hospital
Residency—Bellvue Hospital
and
St. Luke's Hospital, New York City



Arturo F. Salcedo, M.D.
St. Francis Hospital
Honolulu 17, Hawaii
Pathology
University of St. Tomas, 1952
Manila, Philippines
Internship—University of St. Tomas and St. Francis Hospital
Residency—St. Francis Hospital



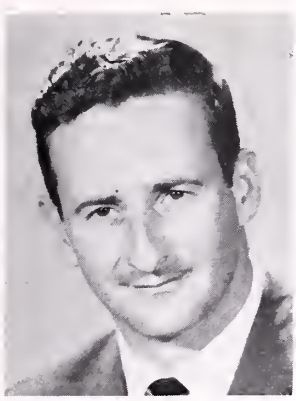
Mitsuo Tottori, M.D.
1024 Piikoi Street
Honolulu, Hawaii
Pediatrics
Tulane University of Louisiana School of Medicine, 1955
Internship—Charity Hospital, New Orleans, Louisiana
Residency—Charity Hospital, New Orleans, Louisiana

Correction: In the last issue Dr. James G. Bennett's specialty was listed as radiology; it should have been listed as pathology.

County Society News



Corazon A. Manayan, M.D.
94-210 Farrington Hwy.
Waipahu, Oahu
Obstetrics & Gynecology
University of St. Tomas, 1950
Manila, Philippines
Internship—St. Francis Hospital
Residency—St. Mary Hospital,
Minneapolis, Minn.



Patrick Walsh, M.D.
1154 Bishop Street
Honolulu 13, Hawaii
General Practice
University of Michigan Medical
School, 1958
Internship—The Queen's Hospital,
Honolulu
Residency—The Queen's Hospital,
Honolulu

Kauai

The regular monthly meeting was held on May 1 at the Wilcox Hospital Library. Dr. Schiro was the only guest present. It was moved that the old Society records be left in the custody of the Kauai Public Library with Mrs. Hadley. Dr. Peter Kim was appointed chairman of the polio committee for the oral vaccine. It was agreed to write to the HMA offices requesting refund of dues to Drs. Boido and Herter. Dr. Boyden reported on the annual HMSA meeting. Dr. Boido moved that the Kauai delegate speak for Kauai on the view that HMA should not attempt to coerce doctors to belong to the AMA. Dr. Brennecke reported on the Medical Care Plans and Fees Committee meeting.

At the May 28 meeting it was announced that the Workman's Compensation Fee Schedule was available through Mr. Larry Ching. A committee was appointed to revise the bylaws. Approval was given for the HMA to act for the Society in establishing a state-wide plan for the over-65 as proposed by the National Blue Shield. In answer to a request from the HMSA, the Society voted to establish a fee of $15.00 for minor surgery, eliminating the $10 to $15 sliding scale now in effect Dr. Kim announced a Civil Defense exercise to be held in the 200-bed hospital at Kalaheo on July 14.

Hawaii

The April 21 meeting was scheduled for 7:30 A.M. at the Naniloa Hotel to hear Dr. William Tucker, who spoke on tuberculosis. Miscellaneous correspondence discussed included the extension of HMSA directors to three years, oral polio vaccine, a thank-you letter from Dr. George Goto, and a letter from Dr. B. R. Mehta, who is interested in associating with a doctor on Hawaii.

A dinner meeting was held on May 11 at the Tropics Lanai to hear Dr. Victor Richards. Prior to the talk presented by the guest speaker on recent trends in cancer therapy, a movie entitled "Cancer Cells" was shown. Two of Hawaii County's HMA delegates, Drs. James A. Mitchel and R. P. Wipperman, reported on the transactions of the annual meeting. A vote taken on the request from the National Foundation to endorse the campaign for the Salk Institute Building lost 8 to 7. An announcement that the Heart Association plans to have a cardiologist from NIH conduct a course in electrocardiography was received with interest.

Two guests were present at the June 14, 1962, meeting: Dr. John Cashman, who spoke on the Peace Corps, and Mr. Burl Yarberry, who reported on the progress and expansion of the Hilo Unit of the University of Hawaii.

It was voted to sponsor an oral polio immunization program. In order to immunize 75% of the island's population, 46,000 doses of each type vaccine was ordered. A movie on Maricopa County's SOS Polio Campaign was shown.

The Secretary of the Woman's Auxiliary was authorized to assist with "Operation Scribe."

It was voted to have the Hawaii Medical Association represent Hawaii County in all fee negotiations. A committee was appointed to study the desirability of uniform fee schedules.

A request from HMSA that a report accompany billing when a fee beyond the minimum is charged for a surgical procedure was discussed. ●

Notes and News

Names in the News

Dr. O. D. Pinkerton's announcement of "Operation Swallow" to stamp out polio was given good PR notices by the local papers.

The University of Hawaii will offer courses in public health for graduates and special students this fall. The new department will be headed by **Dr. Richard K. C. Lee.**

Outstanding rehabilitation results at the Trotter Clinic at Leahi Hospital were announced by **Dr. Hastings H. Walker,** the medical director.

HMSA recently reported a membership rise of 18,119 persons to a total of 232,071.

Drs. Masato Hasegawa, Joseph Stokes III, Mary A. Glover, William Myers, Teru Togasaki, and **Herbert Bowles,** as Friends Medical Society members, expressed concern over the accelerated threat of thermonuclear warfare.

The King-Anderson vs Kerr-Mills battle continues as strongly as ever. On the radio for the profession were **Drs. Frederick Giles** (KORL), **Harry Arnold, Jr., Lyle Bachman, Claude Caver,** and **Toru Nishigaya** (KTRG). On TV were Drs. Bachman and Arnold, Jr.; **Dr. J. A. Burden** discussed medicare financing in a letter to the editor. Also **Dr. Jack R. Watson,** who pointed out flaws in comments on British medicine by local correspondents. **Dr. Leonard W. Larson,** president of the AMA, was chief speaker at the HMA Annual Banquet.

Dr. Alfred Burden's Presidential Address was quoted widely in the local papers. *The Maui News* had a refreshing editorial on it.

Nancy T. Cabot's (Association's secretary) "Free Groceries for the Young?" was apropos and timely.

Dr. Claude Caver has given numerous talks on government medicine to interested civic clubs.

Dr. Justin C. Washburn's lawsuit (charging he had been kept off hospital staffs) against **Drs. Harry L. Arnold, Jr.,** and **J. E. Strode** was dismissed by the Court with prejudice.

Dr. Richard McGovney, retired physician now living at Kula, was recently acclaimed Maui's champion beef barbecuer.

Dr. George F. Straub's hobby of making fine violins was the subject of a feature article in the *Advertiser.*

Dr. John M. Felix and his GP group ably handled the International Scientific Congress of the AAGP. The GP's had the pleasure of hearing **Dr. Philip Thorek** again.

Dr. Pershing Lo made the news again when a patient who recently threatened his life slashed his face, jaw, and neck while he was examining a patient in the security ward of the State Hospital.

Dr. Claude Caver has been elected by the Honolulu Baha'i Community as delegate to the National Convention.

Dr. William Goodhue was the recent winner of the Hawaii's Big Game Fishing Club's Spring Tournament with a 162-pound ahi.

Speakers for the Pharmicists' Convention were **Drs. Robert Rigler, Edward Boone,** and **Casimer Jasinski.** The subject, "Medical Phases of a Disaster."

HMA's 106th Annual Meeting was given quite a splash. The reason—good PR direction by the leaders of HMA.

The special spread carried stories of Kokua Samoa Program with pictures of **Drs. Verne Waite, Thomas Richert, Fred Warshauer,** and **Edward Boone.** HMA President Burden and President-elect Giles were also featured as well as county presidents **Clifford Moran, Pete Okumoto, O. D. Pinkerton,** and **Marvin Brenneke.** Coverage by the press was exceptionally good, including daily reports and President Burden's blast.

There are sparks of changing attitudes in the profession's thinking on politics. **Dr. Clarence F. Chang** announced a testimonial dinner for J. A. Burns just as **Dr. Timothy I. Wee** will head Backers for Burns in Wahiawa. **Dr. Richard Sakimoto** was one of those instrumental in bringing out a great crowd at the Governor Quinn's testimonial. **Dr. R. D. Moore** chaired the affair honoring Ben Dillingham for U. S. Senator.

Congratulations to . . .

Dr. Frank C. Spencer, who was honored by the American Cancer Society for his volunteer service in cancer control. **Dr. I. L. Tilden** presented him with a plaque at the HMA's annual meeting on Maui.

Dr. Richard K. C. Chang, appointed civilian Consultant in Gastro-enterology and Internal Medicine to the U. S. Air Force.

Dr. Vernon K. S. Jim, who was certified by the American Board of Plastic Surgery in May, 1962.

Dr. Frederick L. Giles, new HMA President, and **Dr. Rodney T. West,** President-elect.

Dr. Pete T. Okumoto for receiving the Robins Award for outstanding community service.

Dr. Albert Chun, who won the President's Trophy at the HMA annual golf tournament at the Maui Country Club. **Dr. H. Takaki** was second, and **Dr. Edmund Tompkins,** third. **Dr. Ed Kushi** was low gross winner.

Dr. Paul T. Bruyere, who has become the first State Department of Health executive officer for research, planning, and statistics.

Dr. Richard K. C. Lee, who was presented with a calabash as third winner of the Hawaii Public Health Administrator award at the annual meeting of the Honolulu Chapter of the American Society for Public Administration.

New Affiliations

Dr. Wilbur Lummis, Jr., has retired from the Navy and will open his office for the practice of internal medicine in Honolulu.

Dr. Winfred Y. Lee has joined the Chang-Wakai Clinic in the practice of internal medicine.

Dr. Jerome L. Tucker, ophthalmologist, has opened his office in the new Ala Moana Building.

Dr. Donald T. Smith has left the Straub Clinic and will return to the mainland.

Dr. Hans W. Graumann, radiologist, has moved from Maui to Kaneohe and is now located at 45-939 Kam Highway.

Dr. Raid Chappell has taken up permanent residence in Modesto, California, and **Dr. Paul Y. Tamura** moved over to St. Francis Hospital's Pathology Department July 1.

Dr. David Tien, formerly of Lihue, Kauai, is now associated with **Dr. Joseph T. Lucas.**

MAURICE GORDON
1898-1962

The untimely death of Dr. Mauriee Gordon on May 2, 1962, saddened all who knew him.

Doetor Gordon was born on January 11, 1898, in the small town of Znin, Poland, where he lived during his formative years with his devoted father and mothcr in a very religious and seholarly atmosphere. His father was a rabbi and learned Hebraic scholar so that it is not at all surprising that the son was both deeply religious and very scholarly throughout his lifetime.

His higher edueation was obtained at the universities of Breslau, Freiburg, and Berlin where he reeeived his medieal degrce in 1924. He served internships at the Charité Hospital in Berlin and at the Franklin Hospital in San Franeiseo until February 11, 1925, when he came to Honolulu to join me as a resident at Leahi Hospital. This was the beginning of our great friendship.

In 1928, following his marriage to Golda Hyde, member of a prominent Salt Lake family, he left us at Leahi Hospital and wcnt to Maui. There he praetieed briefly at Hana, and then for a few months as Medical Director of Kula Sanatorium. A deeision was then made to specialize in the fields of otolaryngology and ophthalmology. After studying at the Pennsylvania Post Graduate Hospital in Philadelphia, he joined a medical group in Salt Lake City in 1929, and remained until 1936 when the Gordons decided to return to Honolulu permanently. From that time until the day he was strieken, Doctor Gordon carried on a most active praetice in his specialties.

Those of us who knew him intimately realize that Doetor Gordon was not only a very fine physician but also that he had a rare trait in his charaeter that drew people—patients, friends, or others—to him as a kindly, sympathetic friend to whom they could come freely with their problems for his counsel. Many felt that this superb trait stemmed from his profound religious faith whieh had so deeply pervaded his charaeter. It may be said that to an unusual degree, he inevitably *acted* as well as believed with strong spiritual and moral convictions, as did some of the saintly physieians of early Biblical times.

In addition to being a member of the Honolulu County Medical Society, the Hawaii Medical Association, and the American Medical Association, Doetor Gordon played a very aetive role in the Jewish community. He was a trustee of the Hawaii Jewish Fund, an organization with the primary objeetive of raising money for overseas relief. Also, he was renowned in the Jewish community for his knowledge of classical Hebraie literature and for his outstanding lectures at Temple Emanuel-El in Honolulu where he spoke frequently before Judaism elasses during the past twelve years.

Doctor Gordon was an extremely well-read man and spent much of his free time in serious study in a number of fields of particular interest to him, especially philosophy, Hebraic classical literature, and the sciences. His learned background together with his personal characteristies made him a very engaging eonversationalist. In an argumentative diseussion on some learned subject, he would usually end up the vietor but his opponents never could harbor the slightest resentment because of his invariably courteous, kindly, and gentlemanly manner. This learned man was never the prig or at all pedantie. He was a humanist and a humanitarian, a highly civilized person filled with courtesy, kindness, sympathetic understanding, and tolerance of human beings and their foibles and failings. He loved life and all of the good things in it. He was most decidedly a family man and extremely devoted to his wife and two sons who survive him.

Doctor Gordon's medieal colleagues, who held him in great esteem as a physician, scholar, and gentleman wish to express their deepest sympathy to his beloved family.

HASTINGS H. WALKER, M.D.

Travel News

Dr. and Mrs. P. Howard Liljestrand recently left on the SS "Lurline" for his 25th reunion at Harvard Medical School and to attend the AMA in Chicago.

Dr. and Mrs. Fred K. Lam left to attend the International Rotary Club meeting in Los Angeles and then on to Chicago.

Dr. Vernon K. S. Jim attended the annual meeting of the American Association of Plastic Surgeons in Coronado, California. He also visited the Seattle World's Fair.

continued page 556

Correspondence

King-Anderson vs. Kerr-Mills

TO THE EDITOR:

The meat of Nancy T. Cabot's article is to be found in the following paragraph. "Evaluating the benefits of the Kerr-Mills Law is difficult, since it provides matching Federal funds for the individual states which implement it, and the extent of implementation varies according to the needs and finances of the states. The law has been in effect slightly more than a year, *some 38 states* have already made *some provision to* implement it. At this point, *it is impossible to say if or how soon* the remaining states will implement the Kerr-Mills Law." (*Italics mine, not the author's.*)

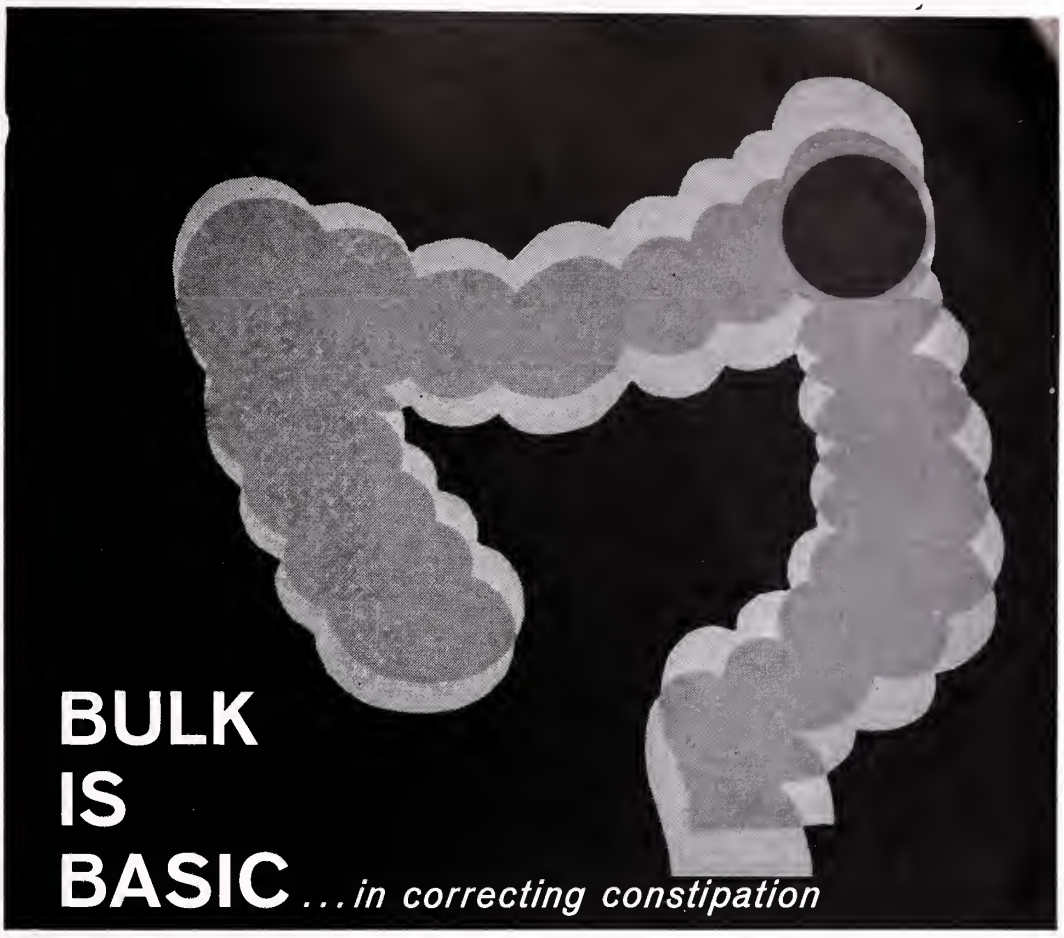
Despite the fact that the Kerr-Mills Law is more than a year old 12 states have made no attempt to implement it. The remaining 38 states have only made *some* provision to implement it. Why hasn't the Kerr-Mills Law been implemented? Simply because the states do not have the money. The benefits of the Kerr-Mills Law are paper benefits and will remain on paper only. To present paper benefits in a discussion as though they were real benefits is intellectual dishonesty. Some might condone this on the grounds that this is a political discussion. No such justification is valid for the medical profession. We know that the issues at stake are the lives and the health of the elderly. The medical profession may well consider that the tarnishment of the physician's image is due, at least in part, to the intellectual dishonesty with which organized medicine faces the issues of the day.

To those of my colleagues who will hasten to refute me, I say now: Your actions and the actions of the states in not implementing the Kerr-Mills Law shout so loudly that your voices are lost in the thunder of real events.

VERNON G. BOIDO, M.D. ●

● *The issues at stake are certainly* NOT *"the lives and the health of the elderly." Even the Administration has gone to no such absurd length in promoting the bill. The issue is whether the service concept is or is not to be introduced into the Social Security system. The lives and health of the elderly are being taken care of almost everywhere under state auspices, with or without Kerr-Mills assistance. Actually, of the 13 states (not 12) that have not expanded their services to the needy aged since Kerr-Mills was enacted, 6 already had excellent, adequate programs. Dr. Boido's colleagues in Hawaii, at least, cannot be charged with failure to implement the Kerr-Mills program: it has been working here since July, 1961. See editorial, page 505.*—ED.





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The stimulus which initiates the defecatory reflex is the fecal mass in the lower sigmoid colon and rectum. Metamucil provides that mass as a bland, nonirritating, easily compressed bulk, similar in consistency to the normal protective mucus of the colon. Taken regularly, Metamucil tends to correct the insensitive reflex of a bowel abused by laxatives and to restore the natural responsiveness to the urge to stool.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

Award Winners



r. James Patterson pre-
nts Dr. Pete T. Okumoto
ith annual Robins Award
r Community Service.



Dr. Toru Nishigaya presents Dr. J. A. Burden with commendation plaque for service rendered the Hawaii Medical Association.



Dr. I. L. Tilden presents Dr. Frank S. Spencer with commendation plaque for outstanding voluntary contribution to the field of cytology.

HAWAII MEDICAL ASSOCIATION

106th Annual Meeting
May 3-6
Maui

Our Presidents



President Giles receives the traditional Fractured Cane from ex-President Burden.



A.M.A. President Larson addresses the meeting.



President-elect Rodney West, new President Giles, and ex-President Al Burden (left to right).







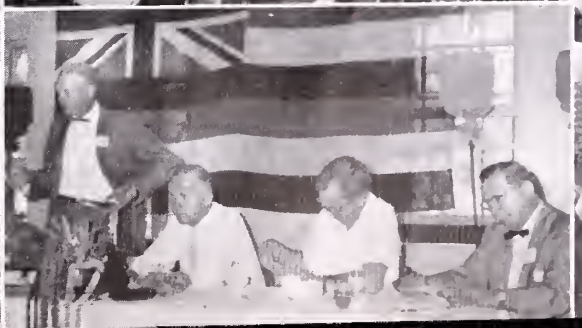
















Our New President



Frederick L. Giles was born in Oolitic, Indiana, September 14, 1909. He received his M.D. from Indiana University in 1934 and interned at Lucas County Hospital in Toledo. During a surgical residency at Detwiler Memorial Hospital in the same city, he met—over the autopsy table—a student bacteriologist, Jane Longnecker. They were married six weeks later, and Fred came to Hawaii for a medical residency at The Queen's Hospital the next year, 1936.

Fred has been a rancher and world traveler for many years—mostly from an armchair; he has encyclopedic knowledge of ranches, both dude and cattle, and faraway places. His reading runs, aside from *Cattleman, Field and Stream, Holiday,* and *National Geographic,* mostly to history and anthropology, and he is apt to do it from four or five AM until 7. Evenings he reads medical journals, but he's not a night owl. Spanish and German occupy part of his study time—in case he should find time to travel to countries where these are spoken.

Tennis kept him slim for the twenty-five years it took him to decide that it was too hot in Hawaii for so vigorous a sport. His most strenuous exercise now is getting in and out of his little open Mercedes Benz, and walking briskly along the beach between swims—occasionally "paced" by a bikini a few steps ahead.

Fred has served the Honolulu County Medical Society almost continuously for 15 years: Program Committee, Board of Governors, Grievance Committee, Industrial Relations Committee, Fee Adjustment Committee, Medical Practice Committee, Medical Care Plans Committee, and Finance Committee. In the State Association he has served on the committees on Tuberculosis, Public Service (chairman, 1949), Chronic Illness, Industrial Relations, Professional Service, Woman's Auxiliary, Physicians' Aid Study, and Salary Structure. He was elected Treasurer, 1958-1960.

In 1937 Fred went to Lihue Plantation for three months and then to Mahelona Tuberculosis Hospital on Kauai, where he stayed four years. A decision to return to the mainland was shelved in favor of accepting an invitation to join the Medical Group, in Honolulu, where he remained. After one year with the group, he accepted a commission in the Army Medical Corps; he served almost four years, all in the Pacific area, and resigned in 1946 with the rank of Lieutenant Colonel. In 1947 he became a diplomate of the American Board of Internal Medicine in the subspecialty of Pulmonary Diseases.

The Giles's three sons—Rick, 22, Tom, 21, and Kent, 17—are in medical school, pre-medical studies, and high school, respectively.

Fred is a member of the American Medical Association, American College of Chest Physicians, American College of Physicians, American Trudeau Society, American Geriatric Society, and the Hawaii Society of Internal Medicine, as well as the American Red Cross and the Honolulu Art Academy.

His busy year as President-elect under a neighbor island president has thoroughly prepared him for the tasks of the presidency. We confidently anticipate a good year for the Association with his experienced hands on the helm. •

106TH ANNUAL MEETING
HAWAII MEDICAL ASSOCIATION

PUUNENE, MAUI

May 3 through May 6

The annual meeting for the one hundred and sixth year of corporate existence of the Hawaii Medical Association was held in Puunene, Maui. The following program was presented:

SCIENTIFIC PROGRAM

Panel Discussions

The Treatment of Congenital Cardiac Anomalies
Moderator: Dr. Unoji Goto
Panelists: Drs. Scott Brainard, Paul Gebauer, John F. Hanley, and Carl Mason

Inborn Errors in Physiology
Moderator: Dr. Norman Kretchmer
Panelists: Drs. William F. Moore, Douglas H. Murray, John R. Stephenson

Gastrointestinal and Biliary Anomalies
Moderator: Dr. Victor Richards
Panelists: Drs. James Cherry, A. O. Haff, Wallace W. S. Loui, William F. Moore

Prenatal and Obstetrical Factors Influencing Congenital Anomalies
Moderator: Dr. C. A. Wyatt
Panelists: Drs. Marion Hanlon, C. C. McCorriston, Robert G. Rigler

Congenital Neuromuscular, Skeletal, and Endocrine Diseases
Moderator: Dr. Norman Kretchmer
Panelists: Drs. Thomas S. Bennett, Donald C. Marshall, Michael Okihiro, Donald E. Poulson, B. A. Richardson

Urinary Tract Anomalies
Moderator: Dr. Andrew Morgan
Panelists: Drs. Herbert Y. H. Chinn, Robert K. Mookini, Walter S. Strode

Papers

The Biochemical Aspects of Genetic Disease
Dr. Norman Kretchmer

Congenital Anomalies of the Intestinal Tract
Dr. Victor Richards

Presidential Address
Dr. J. Alfred Burden

The Biology of Tissue Transplantation
Dr. Victor Richards

Biochemical Aspects of Development
Dr. Norman Kretchmer

SOCIAL PROGRAM

Maui County Medical Society Cocktail Party, Maui Country Club
Cocktails and Dinner Dance, Wailuku Hotel
Breakfast at Maui Couutry Club
Annual Golf Tournament, Maui Country Club
Picnic for physicians at Maui Country Club

MEETINGS

House of Delegates, Puunene Meeting Hall
General Membership, Puunene Meeting Hall
Woman's Auxiliary, Keawakapu

PARTICIPATING DELEGATES

Kauai County:
None

Hawaii County:
James A. Mitchel
Ewart Sarvis
R. P. Wipperman

Honolulu County:
George H. Mills
Andrew L. Morgan
Walter S. Strode
Verne C. Waite
Bernard W. D. Fong
A. L. Vasconcellos
Frederick B. Warshauer
P. H. Liljestrand
Donald W. Brown
William W. L. Dang
Gail G. L. Li
Chew Mung Lum
Walter M. Ozawa
R. Varian Sloan
Herbert Y. H. Chinn
Fugate Carty
Rowlin L. Lichter
Joseph T. Nishimoto
Noboru Ogami
R. Frederick Shepard
Bernard J. B. Yim

Maui County:
Edward Underwood
James F. Fleming

REFERENCE COMMITTEES

No. 1—Public Health
Donald W. Brown
Bernard W. D. Fong
Rowlin L. Lichter
Joseph T. Nishimoto

No. 2—Insurance and Medical Service
R. Varian Sloan
Fugate Carty
Gail G. L. Li
R. Frederick Shepard

No. 3—Miscellaneous Business
Chew Mung Lum
Edward B. Underwood
A. L. Vasconcellos
Frederick B. Warshauer

No. 4—Parliamentary Affairs
Andrew L. Morgan
Noboru Ogami
Bernard J. B. Yim

No. 5—Internal Affairs
Verne C. Waite
William W. L. Dang
James F. Fleming
Walter M. Ozawa

Committees for 1961 and 1962

(Chairmen's names appear in **bold** type)

STANDING COMMITTEES

Arrangements

Clifford F. Moran
Richard K. Chun, Golf Prize
Kenneth A. Haling, Hawaii, Meeting Place
R. J. McArthur, Maui, Golf
William B. Patterson, Maui, Exhibits
John F. Sanders, Maui, Banquet
A. Y. Wong, Housing

American Medical Education Foundation

I. L. Tilden, *Representative*

Awards

Harry L. Arnold, Jr.
Robert Y. Katsuki
H. Q. Pang
M. E. Stevens
S. R. Wallis, Kauai
Henry B. Yuen, Hawaii
C. F. Moran, Maui

Bylaws and Parliamentary

Richard E. Ando
Herbert Y. H. Chinn
Henry A. Manayan
Clarence Y. Sugihara
Rodney T. West
James A. Mitchel, Hawaii
Webster Boyden, Kauai
A. Y. Wong, Maui

Cancer

Grover H. Batten
Harold M. Johnson
Gail G. L. Li
George H. Nip
Walter B. Quisenberry
Irvin L. Tilden
Tokuso Taniguchi, Hawaii
Vernon Boido, Kauai
W. E. Iaconetti, Maui

Chronic Illness and Aging

Shoyei Yamauchi
L. Clagett Beck
Leo Bernstein, Dept. of Health Liaison
Donald W. Brown, Research
Claude V. Caver, Public Relations
John W. Devereux, Indigent Medical Care
John M. Felix, Nursing Homes
Edward F. Furukawa, Mental Health
David I. Katsuki, Indigent Medical Care
P. Howard Liljestrand, Hospitals
Chew Mung Lum
George H. Mills, Hospitals
Ichiro Nadamoto, Nursing Homes
Toru Nishigaya, Rehabilitation
Sumner Price
Walter Quisenberry, Home Care
R. Frederick Shepard, Rehabilitation
Norman R. Sloan, Health Maintenance
Robert S. Spencer, Rehabilitation
George Suzuki, Health Maintenance
Paul Y. Tamura, Research
David Woo, Hawaii
Clyde Ishii, Kauai
Edmund A. Tompkins, Maui

Diabetes

Donald W. Brown
C. S. Brown
Cecil A. Saunders, Jr.
Norman R. Sloan
Louis G. Stuhler
Coolidge S. Wakai
M. H. Chang, Hawaii
Peter Kim, Kauai
K. Izumi, Maui

Emergency Medical Service

Edward W. Boone
Robert F. Bailey
John L. Bell
Leo Bernstein
Frank J. Bruce
Raymond Chang
Thomas Cowan
Cesar B. DeJesus
Robert B. Faus
Raymond H. Hiroshige
Edmund Lee
Fred M. K. Lam, Jr.
P. Howard Liljestrand
Leon E. Mermod
Walter B. Quisenberry
Robert G. Rigler
John Watson
W. H. Wilkinson
R. P. Wipperman, Hawaii
P. M. Cockett, Kauai
Edward B. Underwood, Maui

Examining Board for Hansen's Disease

Edward T. Emura

Federal Medical Service

Grover H. Batten
Homer Benson
Chew Mung Lum
Carl Mason
Edward T. Matsuoka
Randal Nishijima
O. D. Pinkerton
B. Allen Richardson
R. P. Wipperman, Hawaii
S. R. Wallis, Kauai
Edmund Tompkins, Maui

Hawaiian Academy of Science

W. Harold Civin, *Representative*

Health Education

Herbert Y. H. Chinn
Andrew C. Ivy, Jr.
Samuel D. Allison
Doris Jasinski
William Moore
Herbert G. Pang
George Schnack
Nathan Shklov
R. Frederick Shepard
Calvin Sia
Verne C. Waite
S. K. Wong
Ruth Oda, Hawaii
Peter Kim, Kauai
M. L. Hanlon, Maui

Heart

Unoji Goto
Scott C. Brainard
Bernard W. D. Fong
Alfred S. Hartwell
Kikuo Kuramoto
Walter Quisenberry
Marquis E. Stevens
Lester P. K. Yee
Bernard Yim
S. Mizuire, Hawaii
Peter Kim, Kauai
R. J. McArthur, Maui

Hospital Liaison

George H. Mills
L. T. Chun
Ivar J. Larsen
Toru Nishigaya
Roy Tanoue
James T. S. Wong
Bernard J. B. Yim
T. T. Oto, Hawaii
B. O. Wade, Kauai
W. E. Iaconetti, Maui

Legislative

***P. H. Liljestrand**
E. F. Cushnie
J. A. Burden
F. L. Giles
*Richard K. C. Lee
Pete T. Okumoto
O. D. Pinkerton
Marvin Brennecke
Clifford F. Moran
H. E. Crawford
B. O. Wade
R. J. McArthur
*M. E. Stevens
*R. D. Moore
*Toru Nishigaya
*R. E. Ando
*L. Q. Pang

* denotes members of policy setting core

Maternal and Infant Mortality Study

George Goto	1964
Cora Au	1964
Samuel Buist	1964
Clifford K. W. Chock	1962
*L. T. Chun	1962
R. Dimler	1964
Katherine J. Edgar	1964
*Lt. Col. J. P. Fairchild	1962
Charlotte Florine	1964
*Ross Hagino	1963
John Hanley	1963
Robert T. S. Jim	1964
H. James Lambert	1963
Arno J. Mundt	1962
Joseph T. Nishimoto	1962
N. Ogami	1964
*A. C. Oglesby, *Chairman of Subcommittee*	1962
Thomas K. Oshiro	1962
Albert L. Shimamura	1963
*Calvin Sia	1964
*Grant N. Stemmermann	1962
*Philip Watt	1963
James Wong	1964
Jack S. Woodruff	1964
W. H. Wilkinson	1964
Edward Y. F. Wong, Hawaii	1962
Ruth Oda, Hawaii, *alt.*	1962
M. A. Brennecke, Kauai	1962
Clyde Ishii, Kauai, *alt.*	1962
E. D. Willett, Lanai	1962
W. B. Patterson, Maui	1963
W. P. Pfaeltzer, Maui, *alt.*	1963

Past Chairmen, Ex Officio Members
H. E. Bowles
Fugate Carty
Duke Cho Choy
Fred Lam, Sr.
F. D. Nance
S. Nishijima
J. I. F. Reppun
K. S. Tom
C. A. Wyatt

* denotes members of Infant Mortality Study Committee. Date indicates year term expires

Medical Care Plans and Fees

Robert Hunter
Grover Batten
Wm. S. Ito
Chew Mung Lum
George Mills
Richard D. Moore
S. Mizuire
M. Brennecke
C. Moran

Mental Health

Dorothy Natsui
Clifford T. Druecker
Richard S. Horio
K. Y. Lum
James Mertz
Robert S. Spencer
Y. T. Wong
John Musser, Hawaii
Peter Kim, Kauai
F. H. Tong, Maui

Nominating

Edwin K. Chung-Hoon
Harry R. Arnold, Jr.
E. F. Cushnie
Toru Nishigaya

Nurses' Liaison

James W. Cherry
Unoji Goto
William S. Ito
Donald A. Jones
George H. Nip
Linus C. Pauling, Jr.
M. H. Chang, Hawaii
Marvin Brennecke, Kauai
Wolfgang Pfaeltzer, Maui

Personnel

Edward F. Cushnie
Harry L. Arnold, Jr.
Toru Nishigaya
Thomas H. Richert
G. Y. Tomoguchi, Hawaii
Kenneth K. Fujii, Kauai
J. F. Sanders, Maui

Polio

Ichiro Nadamoto
Thomas S. Bennett
M. M. Hasegawa
Ira Hirschy
J. I. F. Reppun
P. T. Okumoto, Hawaii
Peter Kim, Kauai
Edmund Tompkins, Maui

Public Relations

***William H. Stevens**
*J. Alfred Burden
Edward F. Cushnie
*Frederick L. Giles
*Thomas H. Richert
Rodney T. West
Pete T. Okumoto
O. D. Pinkerton
Marvin Brennecke
Clifford F. Moran
William N. Bergin
R. Varian Sloan
B. O. Wade
Edmund A. Tompkins
*Harry L. Arnold, Jr.
*P. Howard Liljestrand
*Robert Chung
*Toru Nishigaya
Herbert G. Pang
G. M. Halpern

* denotes member of Action Section

Radium

George W. Henry
Samuel D. Allison
Philip S. Arthur
Hon C. Chang
Edgar S. Childs
George Goto
Richard D. Moore
John Ohtani
Norman Sloan
Jun-ch'an Wang
Tetsui Watanabe
W. Loo, Hawaii
M. A. Brennecke, Kauai
Raymond M. Otsuka, Maui

School Health

Masato Hasegawa
Katherine J. Edgar
Ross Hagino
John C. Milnor
Henry L. Yim
Calvin Sia
R. Varian Sloan
J. T. Jenkin, Hawaii
P. M. Cockett, Kauai
M. L. Hanlon, Maui

Scientific Program

James W. Cherry
Grover Batten
Unoji Goto
William Moore
George Oakley
Francis Wong, Hawaii
B. O. Wade, Kauai
E. Tompkins, Maui

ADVISORY COMMITTEES

Board of Management Mabel L. Smyth Building

Date indicates expiration of term

M. M. Hasegawa	December 31, 1961
Toru Nishigaya	December 31, 1962
H. Q. Pang, *alt.*	December 31, 1961

Bureau of Crippled Children

Date indicates expiration of term

John Frazer	1963
C. M. Burgess	1962
Katherine J. Edgar	1964
Unoji Goto	1964
Merton Mack	1963
Ichiro Nadamoto	1963
L. Q. Pang	1962
Calvin Sia	1964
Edward Y. F. Wong, Hawaii	1962
Ruth Oda, Hawaii *alternate*	1962
M. A. Brennecke, Kauai	1962
Clyde Ishii, Kauai *alternate*	1962
Edwin D. Willett, Lanai	1962
W. B. Patterson, Maui	1963
W. P. Pfaeltzer, Maui *alternate*	1963
Paul G. Stevens, Molokai	1962

Bureau of Tuberculosis

L. Clagett Beck
Raymond Chang
George W. Henry
John T. Kometani
Robert H. Marks
Francis Won
R. P. Henderson, Hawaii
Peter Kim, Kauai
Edmund A. Tompkins, Maui

Bureau of Venereal Disease

John Chalmers
Samuel D. Allison
Harry L. Arnold, Jr.
Edward T. Emura
Charlotte M. Florine
Koon Sun Fong
Ira Hirschy
Andrew L. Morgan
Linus S. Pauling, Jr.
S. Kasamoto, Hawaii
Vernon Boido, Kauai
F. H. Tong, Maui

Woman's Auxiliary to the Hawaii Medical Association

Lester Kashiwa, Maui
George Garis
R. Varian Sloan
Ed Helms, Hawaii
Clyde Ishii, Kauai

AD HOC COMMITTEES

Association of Professions

A. Leslie Vasconcellos
W. Harold Civin
R. T. Kainuma
M. H. Lichter
R. T. West
Robert Miyamoto, Hawaii
K. Fujii, Kauai
J. E. Andrews, Maui

Hawaii Medical Practice Act Review

B. Allen Richardson
Samuel D. Allison
Leo Bernstein
Thomas F. Fujiwara
Kikuo Kuramoto
Richard K. C. Lee
Irvin L. Tilden
Raymond C. Yap
Samuel Yee
S. Mizuire, Hawaii
William W. Goodhue, Kauai
E. T. Shimokawa, Maui

SPECIAL APPOINTMENTS

The National Foundation's Health Scholarship Committee—C. M. Burgess
Inter-Professional Coordinating—Leabert R. Fernandez, Theodore T. Tomita
Oahu Health Council—E. F. Cushnie, Unoji Goto
Advisory Committee to the Division of Mental Health—Dorothy Natsui
Medical Advisory Committee to the Department of Social Services—
George H. Mills, B. A. Richardson, M. H. Chang, Vernon G. Boido, Joseph E. Andrews

PROCEEDINGS OF THE HOUSE OF DELEGATES

of the Hawaii Medical Association

106th Annual Meeting

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, Dr. J. Alfred Burden, at 1:00 P.M., May 3, 1962, in the Puunene Meeting Hall, Puunene, Maui.

Present: Drs. J. A. Burden, Frederick L. Giles, Rodney T. West, Thomas H. Richert, E. F. Cushnie, Marvin A. Brennecke, O. D. Pinkerton, Clifford F. Moran, Samuel D. Allison, Randal A. Nishijima, William N. Bergin, Joseph E. Andrews, George H. Mills, Andrew L. Morgan, Walter S. Strode, Verne C. Waite, Bernard W. D. Fong, A. L. Vasconcellos, Frederick B. Warshauer, Donald W. Brown, William W. L. Dang, Gail G. L. Li, Chew Mung Lum, Walter M. Ozawa, R. Varian Sloan, Edward Underwood, James F. Fleming.

In addition, Dr. Pinkerton appointed Rowlin Lichter to replace Robert Benson, Joseph T. Nishimoto to replace Allan Leong, Noboru Ogami to replace James T. S. Wong, Bernard J. B. Yim to replace Robert T. S. Jim, Fugate Carty to replace Morton E. Berk, and R. Frederick Shepard to replace Harold M. Johnson. Dr. Pinkerton advised that Drs. R. Varian Sloan, William Ito, and Walter M. Ozawa would be delayed and no alternate was seated for these absent delegates. Drs. R. Varian Sloan and Walter M. Ozawa reported later, Dr. Ito did not.

No other Kauai County member was present to fill the vacancy caused by Dr. Vernon Boido's absence.

Dr. William Bergin said that the Hawaii delegation would be a little late.

The delegates present were certified and seated by the Secretary, Dr. West, who pronounced the roll call in order.

The minutes of the July 21, 1961, and the May 4-7, 1961, meetings were approved as published.

The President's Report was referred to the reference committee on Miscellaneous Business. Dr. Burden advised that his third recommendation was made in order to initiate a thorough discussion on the subject of public relations. He had originally asked for a special Council Meeting and was advised that his observations should go out with the Delegate's Handbook with specific recommendations. He made a recommendation opposite to that of the Public Relations Committee chairman in order that there would be a thorough discussion.

The Secretary's Report was referred without comment to the reference committee on Internal Affairs.

The Treasurer's Report was referred without comment to the reference committee on Internal Affairs.

The county society reports were called for. Dr. Bergin said that he was not prepared to make the Hawaii report in the absence of Dr. Okumoto. Dr. Pinkerton read his report and it was referred to the reference committee on Internal Affairs. Dr. Brennecke had no formal report to make and read a letter from the Secretary of the Kauai County Medical Society which was referred to the reference committee on Internal Affairs. Dr. Moran read the Maui report and it was referred to the reference committee on Internal Affairs.

The reports of the standing and special committees were referred to the reference committees as indicated in the Delegate's Handbook.

A motion was passed to refer all resolutions to reference committees without reading. The President advised that in view of the changes in the roster of delegates he had to make adjustments in the reference committees and reduce each committee to four. The following assignments were made: Parliamentary Affairs—Andrew L. Morgan, chairman; plus Noboru Ogami, Walter S. Strode, and Bernard J. B. Yim. Insurance and Medical Service—Dr. Chew Mung Lum, chairman; plus Edward Underwood, A. L. Vasconcellos, and Frederick B. Warshauer. Public Health—Donald W. Brown, chairman; plus Bernard W. D. Fong, Rowlin L. Lichter, and Joseph T. Nishimoto. Miscellaneous Business—R. Varian Sloan, chairman; plus Fugate Carty, Gail G. L. Li, and R. Frederick Shepard. Internal Affairs—Verne C. Waite, chairman; plus William W. L. Dang, James F. Fleming, and Walter M. Ozawa.

Dr. Bergin asked that Dr. Ewart Sarvis be recognized as a delegate from Hawaii county. He was so recognized, and assigned to the reference committee on Miscellaneous Business.

Dr. Burden welcomed the delegates and said:

It is with a great deal of pleasure that I welcome you to the opening session of the House of Delegates of the 106th Annual meeting of the Hawaii Medical Association.

The accomplishments of the past year are so well outlined in the reports in your delegate's manual, and though I am sure that you have so thoroughly familiarized yourself with these reports, that it would be a waste of your time to review them, I would like to make a few remarks.

Gentlemen, you have been elected as representatives of a very old and honorable organization with a distinguished record of achievement. I am certain that at the current session you gentlemen will add to this list of achievements.

As representatives of this organization you are charged with grave responsibilities of this year, as never before, we are faced with serious problems on both the state and national levels.

With the administration in Washington committed to its program of socialization and dedicated to the passage of the King-Anderson Bill, the threat of Government intervention and control of medicine looms higher on our horizon than ever before. Added to this is the local tendency to introduce more and more bills unfavorable to our profession in the State legislature and the ever increasing critical attitude of the public towards us. It is easy to see that we have no mean problem to contend with.

It behooves us to gird our loins and stand united as never before, realizing that the public is watching us with a critical eye and that we have already been smeared with a label of being more interested in making money than in caring for patients' needs, so that our every decision will be scanned in the light of these accusations, unjust though they may be.

I would like to remind you that although you were elected to your office by the membership of your component societies, you were elected to represent them as members of the Hawaii Medical Association and not as members of a component society.

I would like to quote a few lines from our Constitution. In Article III, which details the purpose of the organization it states, and I quote: "The purpose of the corporation and the objects for which it is organized are . . . To federate and bring into one compact organization the entire medical profession of the State of Hawaii . . . To extend medical knowledge and advance medical science . . . To promote friendly intercourse among physicians . . . To enlighten and direct public opinion in regard to the problems of medicine so that the profession shall become more useful to the public in the prevention and cure of disease . . . To charter, or accredit as affiliates, county or other subordinate medical societies."

Gentlemen, you are here as elected representatives of the membership of the Hawaii Medical Association, and I urge you to bear this in mind in all of your deliberations, forgetting county or clique politics or that you are members of specialty organizations, and act with the unbiased, mature judgment you are capable of in debating the problems we have to face, and reach decisions that will be sound from the standpoint of medical ethics and that will truly represent the entire membership of this Association.

This is especially true in your deliberations over a plan for providing medical care for our aged. The two things we must keep uppermost in our minds are, first, our obligation as physicians to provide the best possible medical care for these oldsters with limited income and, second, that by providing a well balanced program within the limiting framework outlined by the AMA, we are forging a strong weapon to use in the fight against socialized medicine. The Administration feels that because of the emotional appeals involved they have their best chance of enacting legislation since the resounding defeat of the Murray-Dingell-Wagner bill by the American people in 1948. If we can make available better medical care through our voluntary health plans and make this available at a price within the reach of the people of this income level, the King-Anderson Bill will lose all of its attractiveness and we will have won a resounding victory.

The House of Delegates recessed and the reference committee hearings began.

The second session of the House of Delegates was called to order on Friday, May 4, 1962, at 1:25 P.M. The Secretary called the roll and noted that Hawaii, Honolulu, and Kauai Counties did not have their full complement of delegates seated. Dr. Okumoto confirmed the seating of Dr. Sarvis and asked that in addition Drs. James A. Mitchel and R. P. Wipperman be seated. These delegates were seated. Dr. Pinkerton asked that Drs. P. H. Liljestrand and Herbert Y. H. Chinn be seated. These delegates were seated.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your reference committee on Parliamentary Affairs

gave careful consideration to the matters referred to it and makes the following report:

LEGISLATIVE COMMITTEE

Political times have become more desperate. Politics are more intense and more rugged. Noting this, last year the House of Delegates recommended increased activity, including the employment of a professional legislative advisor. The committee undertook this.

The selection of our representative was given long and careful consideration. The committee was acutely aware that it must take care to do more good than harm, and that its activities must be essentially nonpartisan, for our membership is composed of members of both parties. We were fortunate in being able to make arrangements with Mr. Edwin Honda. He is an attorney, a University of Michigan graduate, and a member of the Democratic party. He has had considerable experience with the Legislature and knows many of the legislators personally. He has a physician brother.

The committee has met 14 times. During the legislative session such meetings were held every Thursday noon, at which time Mr. Honda reported on bills in the legislature and their status. Necessary action was discussed at length and any decisions for action carried out by Mr. Honda or by Miss McCaslin and the association staff. Various physicians were called in to appear when apropos. These meetings generally lasted one and one half hours which gave opportunity for discussion of long-range plans.

The annual legislative party was set up and carried off well with Dr. William Stevens serving as master of ceremonies. The tone was entirely one of good-will rather than pressure for anything. A number of legislators spoke and the general attitude was one of friendliness. Two of the legislators in speaking, referred to this "annual" custom, and said that they looked forward to the party. The committee feels strongly that this party should not only be continued annually but should be improved and the budget for it increased. It is not fair that the doctors who give their time to attend the party should also have to support it financially. The membership as a whole should pay for all expenses in connection with the party.

There are always some politically aware doctors of course, but on the whole our future is being set by laymen who are planning for us and organizing our affairs without our even being aware of it. Plato noticed the problem two and a half thousand years ago, saying, "One of the penalities of not engaging in politics is that you are governed by your inferiors."

The Committee feels strongly that we must follow the lead of some of the more active state medical associations in breaking out of our helpless lethargy. We must come out of political coma. We must take the lead instead of being led. We must identify problems that are bothering the population consciously or unconsciously, and start steps to cure them. We must make the public aware that many of the schemes being proposed have already been used in other countries and with what results.

In order that all know exactly where we are trying to go and how, and that there be no uncertainty concerning the use of funds, the committee has been attempting to formulate a set of principles by which to operate, and criteria by which to judge legislation.

The Medical Association has, and will continue, to measure legislation by its effect on the public welfare.

The Committee regards the 1962 legislative session as a practice run for us and learned from it, and recommends the employ of a professional legislative representative for future sessions. During the next session a number of subcommittees will be required, each meeting probably at least twice weekly. It is personal contact with legislators that counts. We must develop a year-around program that will somehow encourage doctors to take to lunch all legislators personally known by some doctor and this certainly includes them all.

We recommend also cooperation with organizations such as the Tax Foundation of Hawaii in helping it establish broader community support.

The thought has been repeatedly expressed that some activities of the government departments belong properly in the province of the private practice of medicine. A detailed study of this and the fragmentation of medical services is suggested as the next project after this legislative session. The committee should develop, in conjunction with government agencies, programs that promote better health for the people of Hawaii.

The committee was invited to assist with preparation of the platform for one of the parties. The committee responded to this and has also offered its services to the other party for the same purpose.

Inasmuch as this was a budget session and the number of bills which would be taken up by the committee were comparatively few, no grading and little individual reviewing was done on the bills that came out of the hopper. However, 57 bills and 6 resolutions were noted to have medical significance. This figure does not include the budget bills.

Budgetary matters which the committee took a definite stand on included support for the $921,721 requested by the Department of Social Services for their MAA (Kerr-Mills) program. This figure came through unchanged. The committee also supported the Juvenile Detention Home's request for funds to establish a medical program. Although most budget requests for unestablished services were cut out, $5,000 was allotted for this purpose. The University of Hawaii's request for money to establish and operate an infirmary was not supported to the extent of the request. The Legislature allowed them enough to expand their physical facilities, but cut their request for personnel. The committee supported the bill which called for a replacement of the mobile x-ray unit on Hawaii. This did not come up for a vote as a bill but was put in the budget and, unless it loses out at the last moment because of pressure for other "pork barrel" items, should be authorized.

Three bills which were separate from the budget activities and which the committee concerned itself with were SUM-17 (HB-275), which would create a permanent Commission on Aging; HB-12, which would put lay people on the Board of Medical Examiners; and HB-520, which defines the term "government physician" as it relates to coroner's physician. The permanent Commission on Aging was approved in the Senate but did not get past the Finance Committee of the House. The committee was warned at the beginning of the session not to be optimistic about the passage of this bill and made the decision to continue to back it but not to try to railroad it through against heavy opposition and thereby hurt our chances of getting something of greater importance accepted, especially since the Commission would undoubtedly be permitted to continue on its interim basis. Towards the end of the session the House did pass a resolution (HCR 39) recommending that the Governor continue supporting this Commission through his contingency fund. HB-12 was killed in committee. HB-520 was pushed through both houses and went to conference before anyone could catch up with it. Basically, this was introduced because the counties, especially Hawaii, did not want the financial responsibility for autopsies. Each county has a different set-up as far as pathologists are concerned and the committee took the stand that the physician assigned should be qualified and experienced. We were able to get this qualification inserted in the bill before it was sent to the Governor.

The next session will be far more active than the one just ending and additional help and support will be needed from the legislative counsel. Items which will be of grave concern to the profession which we know will come up in the next session will include (1) changes in the Medical Practice Act, (2) a bill to permit the incorporation of professional persons (introduced this session by Dick Kennedy but not acted upon), (3) licensing of psychologists and probably (4) bills to change the make-up and responsibilities of the Board of Medical Examiners. There will be many other bills which the physicians

will want to back but we have been advised not to spread ourselves too thin if we want to be effective. Few of the bills that are introduced are enacted into law. In this session, of the bills we followed, only four of the 38 House bills relating to health even got to the Senate. Two of these (the one relating to the coroner's physician and one relating to the income of the blind) were sent to the Governor. There were 19 Senate bills which we followed. Four of these went to the House but none of them reached the Governor's desk.

This is an election year and the next election will be one of the most important to the medical profession that doctors ever have known.

It is nothing less than imperative that physicians assume more political responsibility. They must do so if the practice of medicine is to continue as we have known it.

The committee urges that doctors make monetary contributions to the party of their choice, take part in precinct meetings, arrange for coffee hours where politics is discussed, and attend political dinners.

If physicians are to win favorable legislation and to defeat unfavorable legislation, they must become a part of the community's political picture and perform services which will obligate politicians to them. Otherwise political medicine will be in, and they will be out.

It has been clearly demonstrated that, with rare exceptions, doctors do not have much time to campaign, and to spend hours and days at the legislature. To be effective we must have these things done for us professionally. It will be much more economical too. Most doctors, it seems clear, would rather pay a reasonable amount to have such jobs done for them than to spend entire days doing this job for themselves. This is not to say that doctors will not still have to help and appear before the legislature but at least the groundwork, the legwork, the detailed following of bills, and the business of contacting of legislators can be done for them.

For next year the committee recommends the following financial outlay:

	Cost
1. Continue a legislative advisor	$ 7,500
2. Repeat the legislative party	1,000
3. Extra staff for Hawaii Medical Association during legislative session	1,000
4. Entertaining, dinners, luncheons, extra mailings, etc.	2,500
5. Twelve months informational mailings to membership	325*
Total Budget	$12,325

* Mailing one mimeographed sheet to approximately 650 members:

Typing stencil	$ 1.00
Mimeographing	1.00
Paper	2.10 ($1.50 × 1²⁵ reams)
Envelopes	8.40 ($6.00 × 1²⁵ reams)
Stuffing envelopes	4.00 (3½ hours at $1.15)
Addressing and sorting	2.50 (2¼ hours at $1.15)
Postage	8.13 (650 × 1¼ ¢/piece)
Total for month	$27.13 × 12 = $325.56

The above is not a high figure from which we plan to bargain. This is a firm figure. The committee feels that if it is to do a proper job this is necessary. It represents $22 per member.† It is requested that this fund be provided out of regular dues, if possible, but by assessment if not otherwise possible.

P. H. Liljestrand, M.D.

† Active, dues-paying members (567 as of March 30, 1962).

Legislative Committee

Your reference committee recommends that this report be accepted with the following correction and additions:

1. Paragraph 14, sentence 5, to read as follows: "The University of Hawaii request for money to establish and operate an infirmary was not supported to the extent of the original request.
2. In addition, the reference committee recommends that the President of the Hawaii Medical Association write the Governor of Hawaii, Department of Social Service, and each county government that "qualified and experienced" means a physician trained in pathology.
3. The reference committee recommends that any member society which may be particularly interested in a legislative bill inform the Hawaii Medical Association's Legislative Committee so that adequate liaison may be established.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

BYLAWS AND PARLIAMENTARY COMMITTEE

This committee held one meeting to review the bylaws of the component societies. We found no serious conflicts. One communication was addressed to this committee. The Maternal and Infant Mortality Study Committee is desirous of changing its name by striking out the word "infant" and inserting "perinatal." Since the bylaws state that changes must be circularized at least 60 days before the annual meeting and this communication was not received in time to permit this, we recommend that next year's committee include this request on the agenda of one of its early meetings.

Richard E. Ando, M.D.

Bylaws and Parliamentary Committee

Your reference committee recommends approval of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL PRACTICE ACT STUDY COMMITTEE

The present session of the State Legislature is a budget session. There was one bill, namely House Act No. 12, which was introduced to change memberships of the Boards or Commissions. The last sentence in the bill is self-explanatory: "not more than one-half of the members of any board or commission charged with regulating an industry shall be from or connected with a respective industry." At the time this report was written, no action on this bill had been taken.

I would like to report the experience of the committee in the session of 1961 for the benefit of all members of the Association. We introduced many changes which we felt would better define the practice of medicine in this State. However, we found that the temper of the legislators, especially in the House, was not in our favor. Duruing the hearings, we were placed in a defensive position and were very happy to maintain the present Act without adverse changes. I would say that our Medical Practice Act as it now stands on the books is something that we can live with. In view of our past experience, unless there is something really important that should be changed, it would be best that we proceed cautiously. This is an ad hoc committee and whether it should be disbanded or continue to try to achieve its objectives is a decision the House of Delegates is requested to make. I recommend this committee be disbanded and its duties assigned to the Legislative Committee.

B. Allen Richardson, M.D.

Hawaii Medical Practice Act Study Committee

Your reference committee recommends, that this report not be accepted and that this committee be kept intact and made a subcommittee of the Legislative Committee. Your reference committee further recommends that members of the Board of Medical Examiners be appointed to this subcommittee.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Warshauer felt the Legislative Committee already had enough to do and this is the best way to keep contact and maintain the services of the Medical Practice Act Study Committee. The report was adopted.

SCIENTIFIC PROGRAM COMMITTEE

The objectives of the Scientific Program Committee are contained in the Charter of the Hawaii Medical Association which states that the objectives of the Hawaii Medical Association are, among others, to extend medical knowledge in advanced medical science and to elevate the standards of medical education. Accordingly, the Scientific Program Committee, for the annual meeting, has developed a program which centers around the theme, "Congenital Anomalies." The program is organized in a series of panels, discussing different facets of congenital malformations and presenting discussions by two noted California authorities on these subjects.

Dr. Norman Kretchmer, Professor of Pediatrics at Stanford University, will conduct several of our panels and will present talks at our evening meetings, all relating to the genetics of congenital malformations, particularly related to inborn errors. Also, Dr. Victor Richards, Chief of Surgery at Presbyterian Medical Center and Children's Hospital of San Francisco, will discuss the the surgical aspects of congenital anomalies. Dr. Kretchmer's presence is being made possible through a grant by the National Foundation.

Our panels are related to gastrointestinal, cardiovascular, neurological, orthopedic, urological, and obstetrical factors relating to congenital anomalies. It should be stated that Dr. Richards is participating on our panels, indirectly, as a result of his presence in the State as a postgraduate speaker of the Honolulu County Medical Society, and it is through their generosity that we were able to obtain him as a speaker for our annual State meeting.

JAMES W. CHERRY, M.D.

Scientific Program Committee

Your reference committee recommends approval of this report and also recommends a vote of thanks to the members of the Scientific Program Committee.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Waite recommended to the incoming committee that they strongly consider the abolition of evening scientific meetings. Over the years there has been a gradually declining attendance and in view of the caliber of the speakers, this is unfair to them. Dr. Pinkerton asked how the meetings could be programmed in order to have sufficient time for the scientific sessions. The report was adopted.

ARRANGEMENTS COMMITTEE

This committee has met on numerous occasions since January 1, 1962. The most important problems were those revolving around housing for the annual meeting in May. Under the sterling leadership of Dr. A. Y. Wong it appears that they are being solved.

The meeting hall site was another thorny question but the president of the State Association, Dr. Al Burden, solved this by coming up with the Puunene Club House. At this writing it looks ideal.

Numerous minor difficulties have been overcome with help from various other members of the committee and also with a good assist from the HMA office in Honolulu.

CLIFFORD F. MORAN, M.D.

Arrangements Committee

Your reference committee recommends approval of this report and also recommends that a vote of thanks be given to the members responsible for the organization of this meeting.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

THE WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

This year, as every year, the Woman's Auxiliary to the Hawaii Medical Association has tried to realize its purpose for existence—assistance to the doctors of Hawaii in every possible way.

Lack of communication with large segments of our membership has hindered the fulfillment of this accomplishment in the past. Therefore, it was to the correction of this deficiency that the main efforts of the state organization were directed this year. The visit of our national president, Mrs. Harlan English, for our fall Conference of officers and board members, was an educational experience for all members. In her informal talks at our conference and later to each county auxiliary, Mrs. English translated for us all the purposes and aims of our national organization in terms which could be used by each group at a local level. To many members, the meeting with our highest national officer was the first contact with an auxiliary officer higher than a state official.

Following a suggestion of Mrs. English, after her study of our auxiliary problems, a state newsletter was begun. The publication of the Auxiliary to the Honolulu County Medical Society was incorporated into this paper so that *Rx for Doctors' Wives*, as our new paper is entitled, is now the only auxiliary paper published in the State. Jane Giles is publisher and Kay Benson is the editor. They already have published two issues and plan regular bi-monthly publication next year. The paper contains national, state, and county news, as well as educational features. To many doctors' wives, who are new Auxiliary members since our present fiscal policy has brought us to 100% membership, this newsletter will be a first contact with the Auxiliary.

The most important work among our many active committees was done by the Legislative Committee under the chairmanship of Helen Burden. Responding to the urgency of the times, the chairman of this committee sent out educational material to the wife of each doctor in the State urging personal letters be sent to Congressmen concerning the King-Anderson Bill. Meetings were organized on each island to hear about the WHAM campaign from a representative of the AMA sent here for that purpose. The Ronald Reagan recording was circulated widely among various women's groups. The Honolulu County group also instituted a legislative workshop to stimulate discussion and interest in good government among lay women's organizations. This group was also instrumental in placing the subject of socialized medicine on the agenda of the influential Oahu Council of Women's Clubs.

Mary Ann Carty, the Safety Committee chairman of the Woman's Auxiliary, received state-wide recognition for her slide and lecture program, "Poison Goes Hawaiian." This extremely interesting production, a result of skilled and arduous work by the chairman and her committee, contrives to be both educational and entertaining. First presented to an invited audience of civic leaders, the slides and accompanying lecture are now available to interested groups. So great has been the demand that duplicate slides were made.

The Civil Defense Committee also contributed to the safety of the community in the organization of home preparedness classes. Two members of the Auxiliary became teachers of Civil Defense Classes and one of them has taught ten courses his year. The chairman of this committee is Mrs. Robert Millard.

The cause of the A.M.E.F. remained popular with the

Auxiliary. Betty Fleming reported that $125.00 has been sent to the national headquarters before the proceeds of the benefit dinner planned by the Honolulu County group have been counted.

One general meeting of the Honolulu County group was sponsored by the Mental Health Chairman, Kay Benson. A trip through a home for retarded children was planned to educate the members to the need for legislation to help these unfortunates. Further educational material on mental health problems has been included in state publications.

A project heavily emphasized by our national group, the encouragement of Health Careers, has never really engendered enthusiasm among the auxiliary members of Hawaii. This year, however, several Future Nurses Clubs were formed by the committee chairman, Marian Wade, and educational material distributed to these clubs. This could be a worthwhile area of concentration for future years.

The monumental historical project, "In Memoriam," continued its work this year under the dedicated hand of Betty Katsuki. Ten contemporary biographies, seven new biographies of old entries, and four revised biographies were added to make a total of 350 biographies now compiled. Mrs. Katsuki also added 40 new pictures to the 72 previously collected.

Our two hospitality chairmen, one on Oahu and one on Maui, were presented with difficult and exacting charges. Our Honolulu chairman, Amelia Bailey, planned in minute detail the itinerary, entertainment and, indeed, all arrangements for the most delightful visit of Mrs. English. Her Maui counterpart, Virginia Moran, is responsible for the May Convention to be held on that Island.

All the elected officers of the State Auxiliary have performed their appointed tasks with precision and good will. Our president-elect, Ah Chin Lam, attended the Chicago Conference of the National Auxiliary and reported what she had learned there at our fall conference. Our first vice-president, Dolly Pang, acted as membership chairman and in that capacity checked and corrected the names and addresses of our total membership of 487. Anita Haywood, our secretary, kept the records and our treasurer, Naomi Yamashiro, kept a bank book which always balanced. She was assisted in this task by Ruth Bell, our finance chairman and keeper of the budget.

I am sorry that I must report, for still another year, that one county, Hawaii, remains unorganized into a county auxiliary. It is the hope of the organized membership that the contact with Mrs. English last fall and the further educational material set forth in our newsletter will encourage the formation of an auxiliary there.

The largest county auxiliary, Honolulu, was served in the first part of the year by Lois Lucas and since January by May Horio. Under their leadership, most of the work described above was carried out.

Dora Wallis, as President of the Kauai group, encouraged the auxiliary members there in countless acts of community service, notable among which is extensive aid to the Diabetes Association.

During the first six months of this club year, the Maui Auxiliary was led by Bea Kashiwa and is presently under the guidance of Virginia Moran. This auxiliary has contributed to the Maui Community by providing leadership and service to all community activities, working as individuals rather than a group. Concerted action on Maui is reserved for such tasks as the planning and executing of the entertainment of visiting doctors and wives, such occasions as the coming May convention.

All in all, 1961-1962 has been a year of hard but rewarding work for those of us who have been privileged to serve the Woman's Auxiliary in some special capacity. I believe it has been a year of increased awareness of responsibilities for all members of our group—even those who seldom come to meetings. We hope we have left our Auxiliary a more united and better informed group. This has been our aim.

MRS. JOSEPH E. ANDREWS

Woman's Auxiliary to the Hawaii Medical Association

Your reference committee recommends approval of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The chairman of this committee, Dr. Lester T. Kashiwa, did not submit an annual report.

Advisory Committee to the Woman's Auxiliary

Your reference committee notes with regret that no report was submitted by this committee.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 3 RE: KING-ANDERSON BILL

WHEREAS, Physicians of Hawaii, guided by professional standards and under American's free enterprise system, are now providing excellent medical care for all the people in the State; and

WHEREAS, Hawaii physicians, aware of the financial need of some of our elderly citizens, did support and help secure enactment of the Kerr-Mills law designed to meet this need in a realistic manner; and

WHEREAS, The Revised Laws of Hawaii have been changed to enable this State to take care of the medical needs of its low-income elderly; and

WHEREAS, Since July 1, 1961, the Department of Social Services has provided the low-income elderly medical benefits as needed under the Kerr-Mills provisions; and

WHEREAS, Only 1,300 of our 29,162 citizens over 65 are cash welfare recipients, and only 486 citizens not on the welfare rolls have applied for assistance with their medical care; and

WHEREAS, The Hawaii Medical Association guarantees that no one need forgo medical care because of inability to pay; and

WHEREAS, A recent survey by Senator Hiram L. Fong indicated that 62 per cent of the people questioned were not in favor of compulsory medical care for elderly citizens through increased taxation; and

WHEREAS, The King-Anderson bill, seeking to place medical care for the aged, regardless of need, under Social Security taxation, would finance medical care for some and yet deny it to others; and

WHEREAS, The King-Anderson bill would impose a payroll tax increase on the lower income groups of the working population and would open the door to the inefficiency and defects inevitable in the administration of compulsory welfare programs by the Federal government; and

WHEREAS, The King-Anderson bill would result in a type of medicine that would be of decreased quality and yet more costly than that available through voluntary methods; now, therefore be it

Resolved, That members of the Hawaii Medical Association continue their vigorous opposition to King-Anderson type legislation for medical care; and be it further

Resolved, That all physicians be encouraged to inform and enlist the support of their patients and friends in this effort.

Introduced by:
RICHARD D. MOORE, M.D.

Resolution No. 3 Re: King-Anderson Bill

Your reference committee moves that this resolution be adopted with the following revisions:

1. Paragraph 10 to read as follows: "Whereas, the King-Anderson Bill would ultimately result in a type of medicine that would tend to be of decreased quality

and yet more costly than that available through voluntary methods; and therefore be it"

2. The last paragraph to read as follows:
   "*Resolved*, that all physicians be encouraged to inform and enlist the support of all associated groups concerned with health, their patients, and their friends in this effort; and be it further"
3. An additional resolve be added as follows:
   Resolved, that a copy of this resolution be forwarded to each of Hawaii's elected congressional representatives in Washington.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Giles spoke for a more positive approach and was opposed to the insertion of the word "tend." The President said he would not be adverse to having a copy of the resolution sent to Representative Mills. The report was adopted.

The chairman moved adoption of the report as a whole as amended. Dr. Burden noted that the House had adopted that portion of the reference committee report and accepted the Legislative Committee's recommendation that the membership be assessed up to $22 a person to cover legislative activities. Dr. Morgan advised that this proposal was noted. His reference committee felt this was a fair figure. The chair ruled that since assessments must receive a two-thirds vote, this matter would again be considered under new business. The report as a whole as amended was adopted.

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your reference committee on Public Health gave careful consideration to the matters referred to it and makes the following report:

EXAMINING BOARD FOR HANSEN'S DISEASE

In 1961 the Board met three times at St. Francis Hospital and once at Hale Mohalu. One of the meetings at St. Francis Hospital was fruitless because the patient did not appear. However, he was finally seen at Hale Mohalu and certified to have the lepromatous type of leprosy. All three patients brought up for evaluation were found to have leprosy. Two were young Samoans and one an older Filipino.

I would like to thank Dr. Edwin K. Chung-Hoon for his careful work-ups of the patients and his clearcut presentations.

EDWARD T. EMURA, M.D.

Examining Board for Hansen's Disease

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MATERNAL & INFANT MORTALITY STUDY COMMITTEE

The objectives of the Committee are: (1) To study maternal and infant deaths in order that avoidable factors in such deaths may be reduced or eliminated; and to assure better maternal and infant care through improvement in teaching and practice. (2) To serve as an Advisory Committee to the Department of Health on programs relating to maternal and child health.

Major activities of the Committee for 1961 were as follows:

1. The Committee studied in detail eight maternal deaths. (The ninth maternal death of 1961 has not yet been reviewed.) Three of the eight cases were non-obstetrical, and were due to suicide (2) and brain tumor (1). Of the remaining five, two deaths were considered directly obstetrical and preventable. One was indirectly obstetrical and also considered preventable. Two deaths could not be classified after study because of insufficient information as to the immediate cause of death (autopsy not performed). The lack of autopsy in such cases is highly regrettable. Maternal statistics include all deaths during pregnancy and 90 days thereafter. Lack of information regarding the cause of death, of necessity causes it to be included in the number of maternal deaths for the year, since proof that they are non-obstetrical is not available.
2. Sixteen selected deaths of newborns were studied. Eight of these were considered preventable deaths. Five deaths were considered pediatric as to cause, two were classified as obstetrical, five as combined pediatric and obstetrical. Two could not be classified due to insufficient information. Two were reviewed in sub-committee only, and not classified.
3. Publication of infant case studies was discontinued in June, 1961, because of uncertainty regarding the possibility of litigation resulting from published cases which establish preventability.
4. Two members of the Committee (Drs. J. R. Stephenson and J. F. Hanley) published "Resuscitation of the Newborn" in the July-August issue of the HAWAII MEDICAL JOURNAL. The need for such an article had become apparent in Committee discussions.
5. Dr. Satoru Nishijima presented a preliminary report of a ten-year study (1950-1960) of maternal deaths at the annual meeting, which was attended by neighbor island representatives. A final report is anticipated for the 1962 annual meeting.
6. Members of the Committee attended a meeting on March 24, 1961, of the Maui County Medical Society. A case was presented by Dr. George Goto, Chairman. Dr. Irwin Kaiser, Professor of Obstetrics and Gynecology, University of Utah Medical School, also participated in the discussion.

It was recommended by the Chairman, and approved by the Committee membership, that the name of the Committee again be changed, to the "Maternal and Perinatal Mortality Study Committee of the Hawaii Medical Association." This would be in line with functions and title of state committees as recommended by the American Medical Association, and the Committee asks that the bylaws be changed to permit the official use of this name.

GEORGE GOTO, M.D.

Maternal and Infant Mortality Study Committee

Your reference committee recommends that this be considered notice to the membership that a vote will be taken at the next meeting of the House of Delegates to change the name of the Maternal and Infant Mortality Study Committee to the "Maternal and Perinatal Mortality Study Committee" of the Hawaii Medical Association.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

RADIUM COMMITTEE

There were no problems brought before the Committee this year and hence no meetings were held. It is recommended that the Committee for the following year look into the feasibility of having a survey of all x-ray machines in the State for radiation safety and safe usage, as recommended last year by the A.M.A. This would be a tremendous job, and undoubtedly will require more than one year to accomplish, but obviously would be worth the effort.

Thank you for the privilege of serving on your Committees, and perhaps we can be thankful that this phase of medicine was at least quiet this year.

GEORGE W. HENRY, M.D.

Radium Committee

Your reference committee recommends acceptance of this report and in addition that the name of the Radium Committee be changed to a name more suited to present-day concepts and that this name be proposed by the Radium Committee to the House of Delegates.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HEART COMMITTEE

This committee met once, on March 13. Dr. Kingston Wilcox of the Department of Health discussed the new Health Department project of fluorescent microscopy antibody technique for identifying the three hemolytic streptococcus or Lancefield group A streptococcus. There will be wider application of this technique for identification of other disease processes in the future. The committee recommended that the availability of this technique should be more widely disseminated among the medical profession.

Dr. Norman Sloan stated that only 19% of the indigent rheumatic fever patients released by the Bureau of Crippled Children continued taking penicillin for prophylaxis. He stated that Dr. Rosenblatt was going to undertake a more careful study concerning this problem. The purpose of this study is not for treatment but to encourage patients to pursue private medical care and to evaluate the value of taking penicillin for prophylaxis. Dr. A. S. Hartwell suggested that the health education of the Hawaii Heart Association should in some way participate in this program. The committee approved of this project as a study.

The value of notifying private physicians of heart diseases suspected on routine chest x-rays done by the Public Health Department was discussed. In 1961, 25% of the cases reported to the physicians turned out to be new cases of heart disease. The committee felt that the present policy should be continued but the suspected heart disease should not be revealed to the patient. It was also recommended that the wording of the Clinitron form should be studied.

The subject of cardiac consultation for indigent patients was discussed. It was felt that the cardiac patients on Oahu could be safely and easily referred into the cardiac clinic of one of the hospitals in Honolulu. However, it was recommended that the prevailing service should be made available to the neighbor islands.

Dr. Norman Sloan wanted consideration given to the use of Federal heart funds for the diagnostic procedures in indigent adult cardiac patients. The committee felt that, at the present time, it would be advisable not to use the Federal heart fund for these cases, but to refer them to the existing agencies.

The committee was asked to either approve or disapprove a ten-minute movie entitled "Life in Your Hands," demonstrating external cardiac massage for lay people. The committee approved the use of the movie as instruction for emergency treatment by the Police Department provided it is shown in the presence of a physician. It was advised that the physician should explain the indications and the dangers involved in such a treatment.

UNOJI GOTO, M.D.

Heart Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

The Hawaii Thoracic Society has taken over the functions previously carried out by this committee and since it would have been a duplication of effort, no meetings of the Association's Advisory Committee were held since the last HMA annual meeting. The Hawaii Thoracic Society has the same problems and the same interests and connections with the state and county tuberculosis associations and the Department of Health as the appointed association committee, and the duplication of work has been a great hindrance in trying to call a meeting of this committee.

The committee seeks advice from the House of Delegates on whether it should continue to function and report back to the HMA or whether the Department of Health should go direct to the Hawaii Thoracic Society for advice and guidance. If the House should declare that this committee be permanently disbanded, that section of the bylaws which states there shall be an advisory committee on tuberculosis will have to be deleted.

L. CLAGETT BECK, M.D.

Advisory Committee to the Bureau of Tuberculosis

Your reference committee recommends that this report not be accepted and that the Advisory Committee continue to function as it has in the past.

Mr. Chairman, I move adoption of this portion of the report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF VENEREAL DISEASE

This Committee held no meetings in the past year; hence, there is no formal report of activity. However, we should like to call to the attention of the general membership of the Hawaii Medical Association that there has been an increase in the past year in venereal disease, particularly in gonorrhea and primary syphilis. It has come to our attention and to the attention of the Health Department that many physicians are seeing patients and merely treating them for prostatitis and urethritis without doing adequate laboratory procedures to determine the etiological agent. In some instances, patients have been treated with penicillin or other antibiotics which may have cured gonorrhea but have masked the symptoms of primary syphilis. Because of inadequate investigation and improper follow-up, the epidemiology has not been pursued adequately and consequently there are undiagnosed and untreated cases of gonorrhea and primary syphilis which constitute a definite public health menace.

The membership is urgently requested to pay more particular attention to adequate diagnostic procedures and where these are not readily available that smears be prepared and sent to the Department of Health for diagnosis. Unless and until adequate diagnostic and epidemiological procedures are carried through by private physicians, the increase of venereal disease will constitute a continuing menace to the health of the community.

JOHN F. CHALMERS, M.D.

Advisory Committee to the Bureau of Venereal Disease

Your reference committee recommends that the following sentence be added to the report. "Health Program representative, Edward W. Patton, has been assigned to Hawaii by the Venereal Disease Branch of the Communicable Disease Center of the U. S. Public Health Service to conduct a survey of the venereal disease control program of Hawaii as recommended by the Venereal Disease Committee in its 1960 report." The purpose of this addi-

tion is to introduce Mr. Patton, the reason for his visit to Hawaii, and the purpose of his program in Hawaii.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

CANCER COMMITTEE

Forwarded herewith is the report of the Cancer Commission to the Cancer Committee.

The Cancer Committee has not yet met this year since all matters requiring discussion pertained to the Cancer Commission. Hence the report of the Commission constitutes the report of the Cancer Committee.

MEMBERS OF THE CANCER COMMITTEE: Following is the report of the Cancer Commission to the Cancer Committee for the year 1961-1962.

During the past year the Cancer Commission has continued to meet on a bi-weekly basis, in providing guidance and direction to the Hawaii Tumor Registry and consideration of related matters. Emphasis was placed on efforts to bring the registry into full operation throughout the State, and on clarification of terms and procedures. Considerable progress has been made in meeting our objectives. All hospitals in the State are now formally participating in the Hawaii Tumor Registry system, and a detailed statistical report on cancer patients seen in hospitals in 1960 is anticipated in June, 1962, with a 1961 report to follow in a few months.

Dr. William Haenszel, Chief of the Biometry Branch of the National Cancer Institute, met with the Commission in November, 1961, to discuss a proposed epidemiological investigation of stomach and lung cancer among Japanese in Hawaii that would be integrated with similar studies in California and by Dr. Segi in Japan to determine if shifts in cancer risks among Japanese may be associated with environmental changes resulting from migration. There will be further discussions with Dr. Haenszel in May of this year concerning the manner in which Hawaii will cooperate in this study.

The Commission also met to consider recommendations that a cytology registry be established in Hawaii, financed initially by the American Cancer Society, and that this Commission be the logical body to provide direction to a cytology registry in the same manner that it directs the Hawaii Tumor Registry. A consultant from the mainland, Dr. Calvin Zippin of the University of California Medical School, who was brought in by the American Cancer Society, reported to the Commission his detailed recommendations for setting up a cytology registry in Hawaii. The council of the Hawaii Medical Association at a formal meeting delegated the responsibility of a cytology registry, if set up, to the Cancer Commission. Further study of the recommendations is to be made, and if essential details can be worked out it is probable that a cytology registry will be established.

Members of the Cancer Commission are Drs. Grover H. Batten, chairman, and Shoyei Yamauchi (from the Hawaii Medical Association), W. H. Civin and I. L. Tilden (from the American Cancer Society) and Norman R. Sloan and Doris R. Jasinski (from the Department of Health).

GROVER H. BATTEN, M.D.

Cancer Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH COMMITTEE

The year 1961-1962 has been an exciting one from the standpoint of awareness and action for mental health. This later led to the formation of the joint Commission of Mental Illness and Health. The joint commission report was published culminating a 5-year study in which 36 national organizations participated, and action for mental health was thus formed and was recognized as a "historical contribution to the promotion of mental health and prevention and care of mental illness" by the board of trustees at its New York meeting in June, 1961. In November, 1961, the governors from the 50 states met in Hawaii and pledged their cooperation to meet the needs. Since then, the commission has been meeting at the state level in Chicago. The main purposes of these meetings were to enlighten the public, the misinformed and the uninformed, to increase the psychiatric orientation of all physicians regardless of their specialty, to insure more adequate cares in the hospitals and on the outpatient level. Also, to encourage establishment of night hospitals, sheltered work shops, after-care programs, outpatient departments, clinics, half-way houses, and community mental health centers to replace the large hospitals as treatment centers. Locally, the Mental Health Committee of the Hawaii Medical Association at the state level has had several meetings in order to discuss the matter which has been newly brought to our attention. Dr. Robert Spencer, who has been very active in establishing and coordinating these activities within the Department of Health and the community, has been a valuable contributor in the discussion group whenever the Mental Health Committee met.

The Committee first met on December 8, 1961, at which time Dr. Spencer reported on the November, 1961, Governors' Conference on Mental Health held in Honolulu. Governor Quinn was reported to have been selected chairman of the policy committee. The purpose of the meeting was to discuss the implementation at the state level of the Surgeon General's ad hoc committee recommendations. Dr. Spencer also brought to our attention the State's 6-year mental health program. Specific areas of recommendations include increasing the communities' mental health services. We have at the present time at the state level 7 clinics, 4 of them are located on Oahu and one each on the neighboring islands. On Oahu, there is the 1200 bed State Hospital. On Maui, Kula Sanitarium is used for chronic patients. The active patients are sometimes cared for in the Maui Central Memorial Hospital for day hospital care. In addition, the Wailuku Clinic also takes care of the outpatient cases. Mahelona Hospital on Kauai is also actively participating in the care of chronic patients on that island. More and more, the patients who come from the neighbor islands are kept within their home island. Hawaii has its Puumaile Hospital and Hilo Memorial Hospitals. Its own psychiatrist takes care of a large area and they certainly have great need for an increase in the staff on that island.

The active residency training program is going on in most of the hospitals and clinics on Oahu and the program is increasingly improving. The education of physicians who are interested in psychiatric orientation of medical practice have met with the WICHE program, which is undertaken by the two local doctors, K. Y. Lum and George Schnack.

Another interesting innovation is the soon to be established special school program for the emotionally disturbed children at the University Elementary School.

The Legislative Committee of the Mental Health Association met on January 11, 1962, to discuss the amendment of section 81-27, *Emergency Admission on Incomplete Court Action*, to a period not to exceed 90 days. This is still at a first-draft stage and no conclusion has been reached yet. Dr. George Stevenson has been working very actively on this matter.

The last committee meeting was held April 2, 1962, on the Mabel Smyth lanai. At this time Dr. Spencer brought to us the problem of narcotic control. England has an ambulatory system of treating narcotic addicts. It was noted that the laws have certain exceptions relating to a person who is dying or one who has become medically addicted, and permit doctors to administer doses to those two groups. Many of the addicts are treated at the State Hospital for about two or three weeks at the most and are discharged. The cures are not very remarkable. In Hawaii, it is noted that the problem of ambulatory treat-

ment of narcotics is minor compared to areas such as New York or Chicago. Apparently, there is a very adequate control by the Federal agents locally. The Senate Resolution asking for the study of England's ambulatory system of treating narcotic addicts has been voted on but in view of the present effective controls in Hawaii, it is our recommendation that the Hawaii Medical Association should oppose the introduction of the volunteer system of ambulatory treatment of narcotic addicts in this state at this time.

Dr. Spencer also reported on the first meeting of the Health Department's Advisory Committee on Mental Health which was held recently at the Kaiulani Hotel. About 30 lay and professional representatives were present. This meeting was primarily set up as an orientation meeting to point out the responsibilities of the committee. The purpose of the committee is to feel out the community perception of its mental health needs and to advise the Director of the Department of Health of its findings who in turn reports to the Governor. This committee of ours has been posing a question as to how the Hawaii Medical Association and its physicians can help. I personally feel that we as physicians have a major role in the prevention of mental illness and it should come from the individual physicians taking the leadership.

The current problem of helping the accredition of psychologists has been briefly brought up at the end of this meeting but this will probably require a lot more thought and it should probably be shelved to another meeting. There have been several suggestions as to the future recommendation to the Hawaii Medical Association. (1) One is the evaluation of the insurance coverage for mental illness. The APA committee on health insurance and insurance coverage is making some attempt to fulfill this by collecting data regarding mental health needs. The local insurance coverage as far as this is concerned is somewhat meager, but there are some available. (2) Residential type of care for emotionally disturbed children should be considered. (3) Certainly, more adequate and practical care for the drop-outs from the schools should be our interest if we are to decrease crime and juvenile delinquency. If community needs are to be met, there should be more alertness and dedication among the physicians so that they can work cooperatively with the laymen. Such cooperation entails an appreciation by the physician of his dual role as a citizen and as a physician.

In closing, I, as chairman, wish to thank the various committee members and Miss Lee McCaslin for their excellent cooperation during the past year.

DOROTHY S. NATSUI, M.D.

Mental Health Committee

Your reference committee recommends that the Hawaii Medical Association go on record as being opposed to the introduction of the volunteer system of ambulatory treatment of narcotic addicts in this state at this time. Your reference committee further recommends that the Mental Health Committee study the advisability of establishing a subcommittee on drug addiction.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

SCHOOL HEALTH COMMITTEE

This committee met once, on March 23. Mr. Tate Robinson of the Department of Education was invited to attend the meeting. The committee discussed the physical fitness program and decided the Department of Education was carrying on the program adequately. The written policy of the Department of Education is being considered now.

MASATO M. HASEGAWA, M.D.

School Health Committee

Your reference committee recommends:

1. That a program for medical examinations for all 7th graders be urged and that examinations for those in low-income families who are unable to provide this service for themselves be conducted with the cooperation of the Department of Health, Department of Education, Department of Social Services, and the county medical societies of the Hawaii Medical Association.
2. The following statement be approved for release for Youth Fitness Week, which begins May 6.

"School health services must be family centered. The health of the school-age child and the development of his personality are not independent episodes but are greatly dependent upon the health of the family and of the community, as well as the school environment. The emphasis now is on physical well-being as a part of general fitness for life—physical, mental, emotional, social, and spiritual.

"To attain this goal, continuing health supervision should be available to all children either by the family physician and dentist or through a community resource; that is, according to the patterns of medical services available to the child and his family.

"Our philosophy of family responsibility for the rearing of children underscores the concept that school health programs should supplement the health care which parents provide their children. Parents should be motivated to seek necessary treatment for children with defects to ensure that optimum correction or adjustment occurs.

"One of the factors in the process of physical fitness is the periodic medical examination of apparently normal and healthy youths of school age. It is generally recommended that the two most important periodic examinations are the one prior to school entrance and the one at the onset of adolescence or in about the seventh grade. The evidence at hand indicates that this goal is being achieved by most families with the exception of low-income groups. Arrangements are being made for the medical examinations of seventh graders in low-income families through the cooperation of the Department of Health, the Department of Education, the Department of Social Services, and the Hawaii Medical Association and its component societies.

"Existing professional services are available to fulfill the follow-up requirements revealed by these examinations. This device has successfully provided for the school entrance examinations of first-grade children. Finding children with health problems in all grades requires additional medical examinations whenever something is suspected to be wrong or for other special indications.

"It is important to emphasize that in all this activity, the essential entity is not the defect that may be present but the youngster needing attention.

"The health of the school-age child is the key to the development of a happy, productive, and vigorous adult."

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

DIABETES COMMITTEE

The objective of this committee is to promote both lay and physician interest in knowledge of diabetes mellitus. During the past year an active publicity campaign regarding diabetes was carried on for the lay public. No effort was directed toward the physicians in our community. The publicity campaign was most active during Diabetes Detection Week, November 12 to 18. No actual testing was done in 1961.

Members of the Diabetes Committee were requested to join the American Diabetes Association and there was close cooperation between the two organizations during the year.

I would recommend continued concentration of interest on the lay public rather than on the physician population during the next year.

DONALD W. BROWN, M.D.

Diabetes Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report.

RESOLUTION NO. 5
RE: UNITED FUND DRIVES

WHEREAS, The House of Delegates commends and approves the principle of voluntary health agencies, and

WHEREAS, It is a firm belief of the Hawaii Medical Association that these agencies contribute a creditable service to the communities in our 50th State, and

WHEREAS, The Hawaii Medical Association in its considered opinion believes that these agencies should be free to conduct their own programs of research, public and professional education, and fund raising in their particular spheres of interest, now therefore be it

Resolved, That the Hawaii Medical Association supports the independent fund raising drives of the charitable health organizations and opposes the methods and principles of united health fund drives.

Introduced by:
F. L. GILES, M.D.

Resolution Re: United Fund Drives

Your reference committee recommends that the wording of this resolution be changed to read:

"WHEREAS, The House of Delegates commends and approves the principle of voluntary health agencies, and

"WHEREAS, It is a firm belief of the Hawaii Medical Association that these agencies contribute a creditable service to the communities in our 50th state, and

"WHEREAS, The Hawaii Medical Association in its considered opinion believes that in the spirit of our free society these agencies should be allowed to conduct their own programs of research, public and professional education, and fund raising; now therefore be it

"*Resolved,* That the Hawaii Medical Association continues to support the voluntary, charitable health agencies in their respective independent fund-raising drives."

ACTION:

The chairman advised that his committee wished to amend its original recommendation by adding a fourth whereas; to wit, The right and responsibility of each individual donor to give to the agencies he wishes to give to, and refuse to give to the agencies he does not wish to give to, should be preserved, and cannot be preserved under the United Fund program. He so moved. Dr. Arnold was granted the privilege of the floor to speak for the resolution as amended after a motion was passed to grant him this privilege. The parliamentarian later ruled that this privilege is automatically granted under Chapter IV Section 5 (d) of the Constitution and Bylaws. Dr. Shepard questioned referring to the United Fund as a proper noun. He moved that the amendment be changed and that there be a small "u" and a small "f". The secondary motion was passed. The primary motion was adopted as amended.

The report as a whole was adopted as amended.

A short recess was declared while Mr. James R. Patterson presented the Robins Community Service Award to Dr. Pete T. Okumoto. In making the award Mr. Patterson said:

Dr. Burden, members of the Hawaii Medical Association, honored guests, and friends. In the book *Rascals in Paradise* by Grove Day and that other fellow, the story is told about a learned gentleman of the thirties who foresaw the impending calamities about to engulf the world. He decided that his only salvation was to remove himself to some tropical island far from civilization. So in 1939, one week before Germany invaded Poland, this wise man fled to his chosen idyllic almost unknown South Pacific refuge, Guadalcanal!

In these same thirties, our award winner today, was leaving another Paradise of the Pacific for the mainland, to continue his education and to play his part in life. A native of Hilo, Hawaii, perhaps his beginnings of community awareness began with his interest in competitive swimming at Hilo High School and continued on at the University of Hawaii. He is a former Junior AAU swimming champion. He continued through Stanford where he was a member of the University Swimming Team, obtaining his letter and receiving his B.A. degree there. His medical degree was obtained from the University of Michigan. He volunteered his services to the Army and holds the distinction of being the only Japanese-American to see action with the 10th Mountain Division of the Fifth Army in Italy. Besides the names, Carlisle Barracks, Po Valley, Brenner Pass, Sparrow Hospital, Burns General Hospital; and Company D, these names may mean something: St. Joseph's Hospital, Fort Wayne, Indiana; Kapiolani Maternity Hospital; Veterans Housing in Hilo; and 1956 Kalanianaole Drive. They bring us up to date in part. To complete the picture and see the other activities which resulted in today's presentation, he is a Past President and charter member of the Waiakea Lions Club; Past President of the Hilo Amateur Radio Club, serving valuably in Civil Defense and emergencies; President of the 442nd Veterans Club of Hilo; President of the Hawaii County Medical Society; Chairman of the Advisory Health Committee for the County of Hawaii; a director of the Hawaii County Chapter of the Red Cross; and both past and present member of the Board of Regents of the University of Hawaii, appointed by Governor Quinn. His tireless, time consuming, and selfless contributions as shown by his community service are signposts of individual accomplishment and achievement over and above his professional duties to the community. Here is a man of real stature and great worth to not only Hilo but all of Hawaii-nei. Calling—is KH6AUB here this afternoon? Dr. Pete Okumoto.

It is with sincere respect and great pleasure that I present to you, Dr. Okumoto, on behalf of the Hawaii Medical Association your well deserved Robins Award for Community Service in the State of Hawaii.

Congratulations, Dr. Okumoto, from your fellow practitioners and from all of us at A. H. Robins.

INTERNAL AFFAIRS REFERENCE COMMITTEE

HONOLULU COUNTY REPORT

It is with great pleasure that I take this opportunity to briefly report on the activities of the Honolulu County Medical Society.

During the past year the Board of Governors, Board of Censors, and sixteen committees of our Society have been very active. The fourteen standing committees and two special committees are as follows: Advisory Committee to the Woman's Auxiliary, Charter & Bylaws Committee, Fee Adjustment Committee, Finance Committee, Inter-Professional Relations Committee, Legislative Committee, Medical Care Plans Committee, Medical Practice Committee, Nominating Committee, Parliamentary Committee, Postgraduate Committee, Program Committee, Public Relations Committee, Resolutions Committee, and the two special committees, Continuing Education Committee and Health Committee.

Some of the problems undertaken by the more active committees are as follows:

Fee Adjustment Committee. This committee has studied requests from various agencies and physicians requesting their help in establishing appropriate fees and fee schedules.

Medical Care Plans Committee. The Medical Care Plans Committee has reviewed the existing contract with HMSA and is continuing to study needed revisions in the contract and administrative procedures. The committee has also studied the problem of "double coverage" as it relates to the HMSA contract.

Public Relations Committee. The Public Relations Committee has been very active this year in matters pertaining to better public relations and public service, the most important of which will be the mass oral polio clinics. As you probably read in the newspapers last weekend, the Honolulu County will sponsor Operation Swallow starting in October in an effort to obtain maximum polio immunization for the residents of Oahu.

Medical Practice Committee. This committee is one of the most active of the Honolulu County Medical Society meeting weekly and has handled a great number of complaints from patients against physicians and from physicians against other physicians. This committee serves as a vital public service.

Program Committee. The Program Committee has produced excellent programs for our membership meetings including topics on socio-economics and medical topics.

Postgraduate Committee. The Postgraduate Committee has worked hard to line up an excellent postgraduate series for our county society members. This year they were most fortunate in obtaining Dr. Victor Richards of the Presbyterian Hospital in San Francisco as our postgraduate lecturer. As you are aware we were also fortunate in having Dr. Richards on our program for the State meeting.

Charter & Bylaws Committee. Through the excellent work of our Charter & Bylaws Committee during the past year changes have been made in our Bylaws to encourage attendance at our membership meetings. We have averaged approximately 200 physicians at these meetings which has meant a great deal in stimulating interest and educating the physicians on the problems of medicine.

Continuing Education Committee. The Continuing Education Committee is in the process of raising $10,000 for a survey which will coordinate all of the hospital resident training programs in Honolulu. Through such a program Hawaii can attract more residents, provide a better teaching program, and enhance the quality of medical care which in the end result will better serve the people of Hawaii.

An additional *ad hoc* committee was appointed, the "Health Committee." They are studying and making recommendations relative to public schools physical examinations, a preventative medicine program being sponsored by the Oahu Health Council, and study of the recommendations for establishment of a Congenital Defects Center in Honolulu, a project to which money would be contributed by the National Foundation.

The Honolulu County Medical Society also operates the Bureau of Medical Economics, a collection agency for medical bills, and the Medical Employment Service, a placement service for physicians, dentists, and hospitals. These two offices have provided excellent service to the medical community of Oahu.

The Honolulu Foundation for Medical Care which is sponsored by the Honolulu County Medical Society has made great strides towards implementation of the Foundation type medical care insurance in Hawaii. We have just received word that the first such program involving residents of Hawaii has been underwritten by an insurance carrier for a large restaurant chain which includes some restaurants in Honolulu. This is a major step towards providing more adequate health insurance for our patients. It is anticipated that with this foot in the door, the Foundation concept which has now become a reality will continue to grow.

Mr. President, may I thank you for this opportunity to tell of the many accomplishments of our Society.

KAUAI COUNTY REPORT

The following letter was read by Dr. Brennecke:

Dr. Boido moved that the delegate represent Kauai County Medical Society [*sic*] that Hawaii Medical Association should not attempt to coerce doctors to belong to the AMA. In so doing, the AMA amputated 20 percent of Kauai County Medical Society's membership. Dr. Herter seconded and motion was passed.

MAUI COUNTY REPORT

The Maui County Medical Society has had only one official meeting so far this year. At this meeting on February 20, 1962, both members and their wives heard Mr. William McAuliffe, a lawyer from Chicago, speak about WHAM. There was almost unanimous support to send a representative to attend the newly formed Medical Care Plans and Fees Committee, even though this might lead to an increase of dues.

All efforts the last two months have been devoted to planning for the HMA Annual Meeting on Maui. This has been a big job and everyone has worked hard. If we were to single out any one individual, it would be Dr. A. Y. Wong, the Housing Chairman.

We hope the meeting will be a big success.

Report of the Honolulu, Kauai, and Maui County Societies

Your reference committee recommends acceptance of the Honolulu and Maui County reports. The Kauai County report is disapproved with the recommendation that it be referred to the Bylaws Committee for their disposition.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Chinn rose to a point of order and after conferring with his committee members, the chairman changed his motion to file the Kauai County report and refer it to the Bylaws and Parliamentary Committee. The motion as amended was adopted.

RESOLUTION NO. 4
RE: AMERICAN MEDICAL ASSOCIATION

WHEREAS, Numerous innuendos and claims that the American Medical Association does not represent the majority of American physicians have been made by political opponents of the Association; and

WHEREAS, Similar claims have been made that the American Medical Association does not represent the will of the majority of practicing physicians in America; therefore, be it

Resolved, That the Hawaii Medical Association go on public record as stating emphatically that the American Medical Association does represent the will and desire of the majority of the physicians of Hawaii, insofar as any representative form of government is able to do, and that the present leadership of the American Medical Association enjoys the full confidence and support of the Hawaii Medical Association.

Introduced by:
RICHARD D. MOORE, M.D.

Resolution No. 4 regarding the American Medical Association

Your reference committee recommends acceptance of this resolution without change.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL JOURNAL

Your HAWAII MEDICAL JOURNAL is still limping because of advertising cutbacks, but still ambulatory and being published on time, six times a year. Only the July-August issue, of the last 6, exceeded 100 pages; the last 3 issues have contained 100, 100, and 80. The following tabulation compares allotments of space this past fiscal year as compared with previous years.

AVERAGE NUMBER OF PAGES PER ISSUE

	1958-59	1959-60	1960-61	1961-62
Scientific	16	18	19	17
Features	22	24	17	24
Nurses	8	8	8	6
Advertisements	62	80	60	53
TOTAL	108	130	104	100

The JOURNAL is now being sent to 800 subscribers: 616 physicians, 68 medical technologists, 42 nurses, and 74 miscellaneous. Advertisers and publishers receive 122 free copies, and 182 copies go out for exchange—34 for state medical journals, 93 for foreign publications, and 55 for others.

A few changes have been made in the contents during the year. In May-June, 1961, we published the last Infant Death Case Study Report; the material was stopped by

the Committee for fear of its misuse in court. We also published our first and only issue of the *Pharmacists' Bulletin* in that issue (we are the official journal for the pharmacists' association). In September-October we published the first of a series of reports on poisoning, which are prepared by Dr. Richard K. B. Ho of the Poison Control Center. In the January-February issue we published the first installment of Reports and Snorts, an anonymously edited page of miscellaneous observations, announcements, and even jokes, designed primarily to attract readers into the front part of the magazine. At about this time we added to our staff the first Assistant Editor: Dr. Doris Jasinski. She is taking over a large share of the responsibility for editing of manuscripts. In the most recent issue (March-April) we began a feature page of new county society members, with their pictures, and also started condensing the County Society Reports much more strictly than in the past.

The JOURNAL continues to be a good source of new books for the Hawaii Medical Library. During the fiscal year, 79 books were reviewed and 68 were acknowledged with a one-sentence comment under "Also Received." We think the ratio is wrong: we should review about one-third of those received, on the average, and will try to approach this during the coming year.

We have not cut back the amount of space allotted for original articles: the average space used for this during the past 6 issues was 17 pages. Despite this we have one article awaiting publication since March 10, 1961, and another waiting since August; the remaining articles in our "hopper" number 17, enough for about three issues.

In Memoriam—Doctors of Hawaii has now passed the 6-year mark, with instalment 37 appearing in the March-April issue. This is What's New is being continued as well, by Dr. Fred Gilbert.

The last issue of the JOURNAL to contain the *Inter-Island Nurses Bulletin* was the January-February one. They are planning their own magazine. With our March-April issue we began a new cover, designed by Alec Baird Associates, and changed the typographic style and layout somewhat, with a better, more modern type face (Times Roman, 10 point, with Bodoni Bold headings). The Organization page and the Table of Contents were also redesigned.

Financially the JOURNAL's income for the 1961 fiscal year was $29,361.05, or some $3,100 more than budgeted. Of this amount, $850 was received from the McInerny Foundation to defray expenses for publishing the special trauma issue. The full amount was not used and $448.56 was returned to them via Dr. F. J. Pinkerton, who arranged for this assistance. The JOURNAL's direct expenses amounted to $24,641.35, which would have left the JOURNAL with a profit of $4,719.70 if the prorated salaries, rent, telephone, taxes, etc., amounting to $6,320.42, had not been debited to the JOURNAL. The net loss in the report is $1,600.72, or $110.72 more than budgeted. None of these figures had been audited at the time this report was made. We expect the advertising picture to brighten slowly and ultimately to relieve us of this so-called deficit. We are tempted to inquire how many employees could be dismissed and how many office facilities and services could be dispensed with if the publication of the JOURNAL were to be discontinued. We suspect none. It is difficult to anticipate what difference the withdrawal of the nurses will make in the financial picture of the JOURNAL but with the almost certain increase in postal rates, the withdrawal should result in a financial gain rather than a loss.

Meanwhile, though we are never satisfied with the JOURNAL, we are pleased with it, and recommend its continued publication on the same basis as in the past.

HARRY L. ARNOLD, JR., M.D.

Hawaii Medical Journal

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MABEL L. SMYTH MEMORIAL BUILDING, BOARD OF MANAGEMENT

During 1961 The Hawaii Medical Association was represented on the Board of Management of the Mabel Smyth Building by Dr. M. Hasegawa, and Dr. Toru Nishigaya with Dr. H. Q. Pang as alternate. The Hawaii Nurses' Association was represented by Mrs. Mary Walsh and Miss Alison MacBride, and The Queen's Hospital was represented by Mr. A. J. Hebert.

Activity in the building has increased in some areas.

	Usage	*Attendance*
Auditorium	183	24,712
Committee meetings	421	5,780
Refreshments served	32	2,527

There were 132 more committee meetings than last year with an attendance increase of 1,664.

Activity on the Nurses and Physicians Exchange was as follows:

Incoming calls on the Physicians Exchange	47,798
Outgoing calls on the Physicians Exchange	24,275

Unfortunately we lost twelve of our members to a rival answering service. This will reduce our income by $2,016.00 a year, which we cannot afford to lose. A study is being made on the feasibility of putting in an intercepted answering service.

The plans we had last year to build a basement under the central part of the building were unavoidably delayed. However, we believe that we are again moving towards our goal.

In June of 1961 when the Hawaii Medical Library plans were put out to bid it was found that there was a conflict of interest regarding access to the back of the auditorium. A meeting was called which was attended by representatives of the Library, Queen's, Mabel Smyth Building, and Queen Emma Lands, and the problem was worked out. Mr. Alex Smith of Queen Emma Lands said that when the lease with the Library is drawn, the line will be clearly marked.

It is doubtful if we will keep within our budget this year. Revenue from the auditorium as well as the exchange has dropped. Total income for the last fiscal year was up $1,122.00 over the previous year, to $16,847.11. Expenses were $12,404.22. After a transfer of $2,693.00 to the building fund, the net gain was $1,911.89.

TORU NISHIGAYA, M.D.

Board of Management of the Mabel L. Smyth Building

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

SECRETARY'S REPORT

The total membership of the Association, in both classes, as of December 31, 1961, was 627. Due to a change in membership classifications under the new by-laws and an error in reporting Honolulu County's regular membership total last year (the regular membership total should have been 451 instead of 448), it is not possible to make accurate comparisons. However, the nearest comparable figure would show an increase of 20 active members and a decrease of 6 inactive members.

The total number of physicians licensed to practice medicine in Hawaii as of December 31, 1961, was approximately 944 or 61 more than last year. Of these 707, or 45 more than last year, reside in Hawaii. Since the Department of Health has not brought these statistics

up to date since April of 1960, the accuracy of these figures cannot be guaranteed.

As of December 31, 1961, there were 518 active members of the American Medical Association, an increase of 15 over December 31, 1960.

By counties the membership is made up as follows:

	Active	Inactive	Total	Active Dues Waived	Total Active Dues Paying
Hawaii	51	....	51	6	46
Honolulu	496	31	527	17	479
Kauai	13	1	14	1	12
Maui	35	0	35	3	32
	595	32	627	27	569

There is still inconsistent membership reporting but there has been a decided improvement since January.

The following is a summary of some of the more important actions taken by the Council during the three meetings it has held since the last annual meeting:

On July 21, 1961, the Council (1) declined to take any action on podiatry pending the formation of a new committee or commission under the AMA. This meeting was called primarily to discuss the relationship between the HMA and the HMSA, which was the subject of the special House of Delegates meeting which was held immediately after the adjournment of the Council meeting.

On November 8, 1961, the Council (1) decreed that the waiver of dues be confined to the criteria set forth in the bylaws, (2) approved the use of HMA funds for Mabel Smyth Building improvements provided proper safeguards are incorporated in the transaction, (3) voted to increase the neighbor island councilors' per diem allowance from $10.00 to $20.00, (4) moved to abandon the mandatory policy of holding at least one Council meeting each year on a neighbor island in favor of scheduling these neighbor island meetings only when the Council desires that they be held there, (5) approved of the proposed statewide survey of hospitals, (6) approved of the principle of engaging a legislative consultant.

On January 30, 1962, the Council (1) declined the Eli Lilly Co. offer of a cash donation in favor of their continuing to support the annual meeting with a booth, (2) adopted the 1960 California Relative Value Study without change, (3) requested the President to appoint a committee to work with the relative value schedule in relation to the component societies, (4) approved of the establishment of a state-wide cytology registry to be under the direction and control of the Hawaii Cancer Commission, (5) approved the budget for 1962, (6) approved the purchase of President's Plaque to be hung in the Mabel Smyth Building, (7) went on record as favoring a study to determine the need and advisability of establishing a two-year medical school in Hawaii.

The Council voted by mail to set the date of the 1963 annual meeting. The dates selected were May 2 to 5. I recommend that the House of Delegates confirm this date and grant the Council permission to change the time if such change should become necessary.

RODNEY T. WEST, M.D.

Secretary's Report

Your reference committee recommends acceptance of this report and reacts favorably to its recommendation referable to the time of the 1963 meeting.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

AWARDS COMMITTEE

Your Awards Committee met twice and considered a number of candidates for the Robins Community Service Award, including 18 physicians suggested by 22 members of the Association who replied to a request for nominations for this honor. One received 3 nominations, and two received 2; the others received one each. The committee nominated, following its second meeting, a doctor whose many qualifications are enumerated in the citation.

Candidates for the Oahu Health Council citation were also considered and the Hawaii Medical Association's nominee submitted to that organization.

HARRY L. ARNOLD, JR., M.D.

Awards Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

TREASURER'S REPORT

The General Fund as of December 31, 1961, as corrected by the auditor, was $35,599.19, which included cash on hand, cash in the bank, inventory, liabilities, furniture, etc. This represents a net increase of $5,051.21 over the amount reported December 31, 1960. A transfer of funds from the checking to the savings account did not take place until June when $5,000 was placed in the State Savings and Loan Association. In November it was necessary to withdraw $3,500 to cover operating expenses for the balance of the year and this money was taken out of the Territorial Savings and Loan Association. The reserve funds of the Association are now kept in four separate savings and loan accounts.

The following budget was approved by the Council at its January 30, 1962, meeting:

BUDGET FOR 1962

	1961 BUDGET	1961 ACTUAL	1962 BUDGET
INCOME:			
Dues	$22,000	$22,064.75	$34,260
JOURNAL (See Schedule I)	(1,490)	(912.14)	30
Annual Meeting (See Schedule II)	4,870	4,942.70	4,460
Interest	1,180	1,269.49	1,500
Miscellaneous	420	586.88	600
Total	$26,980	$27,951.72	$40,850
Public Relations Assessment	8,250	7,866.27	—
Total	$35,230	$35,817.99	$40,850
EXPENSES:			
A.M.A. Convention	$ 3,300	$ 2,885.72	$ 3,120
Audit and Accounting	1,100	1,100.00	1,280
Automobile Expenses	600	600.00	600
Council Expenses			
Travel	750	498.33	500
Meals and Rooms	250	219.08	200
Per Diem	190	148.54	320
Donations	330	225.00	330
Entertainment	200	15.63	300
Insurance	200	149.20	150
Health Education Committee	650	575.17	650
Library	100	100.00	100
Legislative Committee	1,500	916.50	3,500
Miscellaneous	300	485.96	600
Postage	750	776.12	800
President's Contingency Fund	300	50.00	1,500
Rent	1,850	1,848.00	1,850
Repairs and Maintenance	100	138.01	150
Salaries	14,770	14,426.34	14,770
Stationery, Printing, and Supplies	980	1,383.61	1,400
Subscriptions and Dues	320	321.00	360
Taxes (Social Security, etc.)	440	297.67	350
Telephone and Cable	1,000	730.25	1,000
Travel	410	330.18	350
Bylaws Printing	200	100.30	—
Furniture and Fixtures	260	—	1,000
Public Relations Program (Schedule III)	8,250	6,242.39	10,000
Woman's Auxiliary	2,750	2,672.50	2,850
Total Expenses	$41,850	$37,235.50	$48,030
Less Reimbursed JOURNAL Expenses	6,620	5,939.51	7,180
Less Reimbursed Legislative Committee Salaries	—	529.21	—
Total Expenses	$35,230	$30,766.78	$40,850
EXCESS OF INCOME OVER EXPENSES	—	$ 5,051.21	—

The public relations program will be financed from general revenues in 1962 rather than by assessment as

was the case in 1961. Therefore, no excess of income over expenses is shown. The amount allotted in the budget for this program is $10,000, broken down as follows:

PUBLIC RELATIONS PROGRAM

	1961 Budget	1961 Actual	1962 Budget
INCOME:			
Assessments	$ 8,250	$ 7,866.27	$ —
EXPENSES:			
Radio Program	$ —	$ —	$ 1,200
Salary for Hugh Lytle	5,000	4,999.92	6,000
P. R. Conference	550	542.26	560
Dues to M.S.E.A.	10	20.00	10
Subscription to P. R. Magazine	25	70.00	—
Postage	300	.30	—
Stationery and Printing	600	27.35	—
Telephone and Cable	180	119.76	—
Travel	190	48.61	100
Miscellaneous	1,395	414.29	2,130
Total Expenses	$ 8,250	$ 6,242.49	$10,000
EXCESS OF INCOME OVER EXPENSES	$ —	$ 1,623.78	$ —

Following the system instituted in 1959, the HAWAII MEDICAL JOURNAL expenses were kept separate and the prorated expenses reimbursed to the Association. The current year's operations are difficult to forecast because of the changes necessitated by the withdrawal of the Hawaii Nurses Association. It should be noted that the loss shown for the JOURNAL is a "book" loss and does not mean that the publication is a financial liability to the Association since the HMA was reimbursed in the amount of $5,939.51 by the JOURNAL.

JOURNAL BUDGET

	1961 Budget	1961 Actual*	1962 Budget
INCOME:			
Advertising	$21,750	$23,713.80	$23,730
Sales and Subscription	4,450	4,797.25	4,300
Total	$26,200	$28,511.05	$28,030
Add Reimbursement from Straub Clinic and McInerny Foundation	—	850.00	—
Total Income	$26,200	$29,361.05	$28,030
EXPENSES:			
Auto Allowances	$ 300	$ 300.00	$ 300
Commissions Paid	680	860.84	860
Discounts Allowed	1,500	2,530.07	2,530
Miscellaneous	10	25.45	100
Postage	300	149.71	170
Printing	18,500	19,969.52	17,000
Rent	920	924.00	930
Salaries	5,000	5,001.07	5,300
Stationery and Supplies	50	345.20	150
Telephone	250	245.31	480
Taxes	150	150.04	150
Copyrights	30	12.00	30
Dr. Pinkerton (See Reimbursement)	—	448.56	—
Total Expense	$27,690	$30,961.77	$28,000
EXCESS OF EXPENSE OVER INCOME	$(1,490)	$(1,600.72)	$ 30

* Not audited.

The annual meeting income was predicated on a registration of 110 local doctors and 10 mainland doctors. At the time the budget was prepared 46 exhibitors had indicated that they would participate but it is now obvious that the quota of 40 will not be filled. Coca-Cola will not be asked to pay for a booth since the meeting is on Maui. Annual meeting income is an important source of income for our operating expenses.

ANNUAL MEETING

	1961 Budget	1961 Actual	1962 Budget
Registration	$2,605.00	$2,663.90	$1,340.00
Banquet	20.00	(176.00)	—
Breakfasts	—	113.70	—
Picnic	20.00	18.97	—
Exhibitors	2,175.00	2,322.13	3,120.00
Total	$4,820.00	$4,942.70	$4,460.00

The Golf Fund debt is slowly being liquidated and it is recommended that efforts be continued to eliminate this deficit.

Two policy changes were adopted by the Council: The AMA Delegates' per diem allowance was increased to $35.00 a day and the Councilors' per diem allowance was increased to $20.

The bills for the Physician's Benevolent Fund were sent out in May and as of December 31, 1961.

HAWAII PHYSICIANS FUND

INCREASE IN FUND:	
Total amount remitted by various doctors during 1961	$4,330.00
Interest income	215.08
Net increase for year ended December 31, 1961	$4,545.08
Physicians' Benevolent Fund, January 1, 1961	3,890.36
Physicians' Benevolent Fund, December 31, 1961	$8,435.44

The figures set forth in this report have been audited. However, the auditor's written comments were not available for transmittal with this report. There were four minor changes in the corrected figures and one major adjustment. The major adjustment decreased the book loss on the JOURNAL from $1,600.72 to $912.14. The reasons for this will be taken up at the next Council meeting. It is apparently a matter of entry since all the changes made by the auditor made a total difference in the amount of income over expenses of only $30.14.

It is recommended that the auditing services of Mr. Frank Hough be retained.

No increase in dues for 1963 is recommended.

THOMAS H. RICHERT, M.D.

Treasurer's Report

Your reference committee recommends acceptance of this budget and report and reacts favorably to the treasurer's recommendations.

ACTION:

The chairman moved adoption of this portion of the report. The President asked if the delegates were aware of the contents of the Treasurer's Report and received an affirmative answer. The motion was adopted.

The chairman moved adoption of the report as a whole as amended. It was adopted.

PERSONNEL COMMITTEE

This Committee met once during the year, on October 13, 1961.

Before the last annual meeting it was decided to use the Honolulu County Medical Society's personnel policies, and this policy has continued.

Further work will be necessary before we will be operating a well-run personnel routine.

EDWARD CUSHNIE, M.D.

Personnel Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your reference committee on Miscellaneous Business gave careful consideration to the matters referred to it and makes the following report:

AMERICAN MEDICAL EDUCATION FOUNDATION

The AMEF has become a part of the American Medical Association Education and Research foundation (AMA-

ERF). Information on the new format has not yet been received. Although not complete, our records show that Hawaii's physicians contributed $4,052.52 during the eleven-month period ending December 31, 1961. This cannot be compared directly with the $4,998.50 in last year's report because a different period of time is involved. The figure of $4,052.52 includes approximately $500.00 from county society woman's auxiliary groups for which thanks should be given. Several physicians gave more than $100.00 during this time period, but it is difficult to give names because some gave several times during the year, and several gave large donations in December, 1961, which appeared on the January, 1962, report. Your Chairman apologizes for not pushing this program with the vigor and energy it deserves. In the future it would be advisable to make the report on a calendar year basis.

I. L. Tilden, M.D.

American Medical Education Foundation

Your reference committee recommends acceptance of this report. It further recommends that in the future this report be made on a calendar-year basis.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE TO STUDY ASSOCIATION OF PROFESSIONS

This committee met September 26 and decided that the chairman should meet with members of other professions to determine their interest and desire to organize such an association. When Marjorie Shearon was in Honolulu in October cards were mailed to all members of the engineering, dental, legal, and architectural societies, inviting them to hear her talk at the Princess Kaiulani.

On January 15 Mr. Lytle arranged a meeting at the Pacific Club of representatives of each of the five professions proposed for the nucleus of an association. At the first meeting he was asked to carry on as chairman pro tem and to continue to spearhead the move to organize an association of professions in Hawaii.

There was an apparent expression of apprehension by some groups represented that their members felt the physicians were behind this to get support of the other professions in face of medicine's dilemma in socialization of medicine. We attempted to remove this fear, advising that the physicians are merely another group in a huge project. Mr. Lytle has attempted to get others in the group to take the initiative. A second meeting of the group was held and as it now stands, each profession must take the proposal back to its governing body for approval.

The Hawaii Medical Association has already approved such an association in principle. Approval is now requested for authority to go ahead and become a participating member. The fee for this membership will probably be $50.

A. L. Vasconcellos, M.D.

Committee to Study Association of Professions

Your reference committee recommends that the report of this committee be accepted.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HAWAIIAN ACADEMY OF SCIENCE

The 5th Annual Science Fair was held in March and the usual HMA prizes were awarded to two outstanding exhibits in the senior field relating to medicine and one in the junior field. This year "wish" awards were given instead of cash. The contestants selected their own gifts from suitable science catalogs.

There has been a distinct increase in the number and quality of medical exhibits, perhaps indicating an increased interest in medicine, and I recommend that the HMA continue to support the Hawaii Science Fair in the same manner as it has in the past.

W. Harold Civin, M.D.

Hawaiian Academy of Science Committee

Your reference committee recommends the acceptance of this report and further recommends that members of the Hawaii Medical Association be encouraged to join the Hawaiian Academy of Science.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

NURSES' LIAISON COMMITTEE

The chairman of this committee regrets to report that due to the press of other matters, he was unable to arrange for a meeting with the nurses during the past year. There is undoubtedly value in this type of committee and it is recommended that the chairmanship during the coming year be assigned to a doctor who will have the time to work with the nurses in an effort to develop better understanding between the two professions.

James W. Cherry, M.D.

Nurses Liaison Committee

Your reference committee recommends acceptance of this committee's report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

POLIO COMMITTEE

The Polio Committee of the HMA has during the year, 1961 to 1962, been chiefly concerned with the Sabin or oral polio vaccine. A committee meeting in late 1961 was held and at that time a recommendation was made that each local county medical society should undertake mass immunization of the population using the oral vaccine. Each local county society should determine its own particular operational set-up; that is, each local county society be allowed to determine how the mass immunization program should be developed in its county. At that time it was also suggested that the immunization be carried out only when all three types of vaccine are available. The meeting was also attended by the Health Department officials.

The committee met once again on March 27, 1962. At this time, it was reaffirmed that the oral vaccine be given as a community program and that the doctors should take the initiative for mass immunization of the population. This to follow the general outline of the "Operation Hypo." However, in this particular instance, the cooperation of the Pharmaceutical Society for assistance during the immunization program was recommended.

The mass immunization carried out in Maricopa County (Phoenix, Arizona) was discussed and the news clippings and modus operandi of the above project were distributed to each local county medical society. At the March 22, 1962, the target date for the mass immunization was October 9, 1962. The reason for this is that availability of the three vaccines was still not very definite. However, it is thought that by next October all these three vaccines will be definitely available in quantities sufficient to permit a statewide program. Also the reason for the above target date was the desire to coordinate the immunization with the school program. A charge of 25¢ a person was recommended. However, no recommendation was made on the handling of the State

funds which are available for the 18-and-under group. It was also reiterated at this time that recommendation for the continued use of the Salk vaccine be promoted until the mass immunization is instituted by each local county medical society in the latter part of 1962.

I. NADAMOTO, M.D.

Polio Committee

Your reference committee recommends acceptance of this committee's report with the following changes: Third paragraph: The date March 22 be changed to March 27 to correspond with the proper date of the committee meeting and that the target date for mass immunization be October, 1962. Also in the same paragraph, the words "a charge of 25c a person" be eliminated and the following be substituted: "That a nominal charge be made, depending on cost, and that the charge be made specifically for those not covered in the State of Hawaii program; i.e., those who are over 18 years of age."

ACTION:

The chairman moved adoption of this portion of the report as corrected. It was adopted.

HEALTH EDUCATION COMMITTEE

Throughout the year this committee held monthly meetings on each first Friday. It was decided to reorganize the committee and instead of the entire committee having full responsibility for each program, a team of two members was appointed to supervise the panel during the early rehearsals, and the rest of the committee came in to help in the final stages. We were a little slow in the beginning, but eventually produced a better class of program with more efficiency and less work.

The following programs were produced: (1) *Cancer of the Upper Digestive System* with Drs. Richard K. C. Chang, Verne C. Waite, Y. K. Yoshida, Paul Y. Tamura, and Charles S. Judd, Jr. (2) *Fallout* with Drs. Frederick L. Giles, Edward W. Boone, and Robert A. Nordyke. (3) *What's In A Picture* with Drs. William Moore, Gordon Liese, Robert Rigler, and Calvin Sia. (4) *Poison Beware* with Drs. Richard Ho and John Carson plus Mr. Cliff Coleman. (5) *Hear This* with Drs. L. Q. Pang, Howard Honda, Donald Wright, and John Watson. The cancer program is the first in a series of two and the second program is now in the rehearsal stage as is one on food quackery. The hearing program has been taped but has not as yet been scheduled. A program on psychiatry has been taped but that will be dealt with later in the report. A film "Diabetics Unknown" was shown during Diabetes Detection Week at the request of the Diabetes Committee. In addition the committee reviewed three films which the HMSA wished to have shown on TV and gave approval for their release as they were considered to be in the best interests of public health education.

It became apparent that the TV station was offering us less prime time. One of the reasons for this is because advertising and paid programs are more numerous and therefore prime time is not available for public service programs as such. In addition, the professional shows built around medical subjects decreased the interest in our program and our viewing audience has been gradually diminishing. The committee had often discussed the possibility of producing a conversation-type program and the TV station advised that they would assist us in this production and offered prime time if it were done. Not all subjects are adaptable to this format. However, it was felt that one on psychiatry would be well suited to the informal type presentation. A program was taped with Drs. Stevens, Schnack, Furukawa, and Spencer. This was a tremendous success, but unfortunately because of the death of the moderator it could not be shown. The success of such a program is dependent upon the moderator and the committee recommends that further efforts be made to produce extemporaneous programs if an experienced and qualified moderator can be found. The proposed program on socialized medicine would fit well into this format.

The other approach to getting prime time is to get a sponsor who will pay for the TV time. We have been assured by the station that attractive programs can be produced. At a joint meeting with the Public Relations Committee, it was agreed that we should recommend to the House of Delegates that permission be given to solicit sponsorship of the TV series. Insurance companies have much to lose by socialized medicine and they might be interested in maintaining the public relations of the physicians in private practice. Another possibility is a pharmaceutical firm, or the association of pharmaceutical firms.

It is well known that TV is the ideal mode to reach the public. We realize the timely importance of improving the public relations of the medical profession and of educating the public on health matters. The Medical Association should be assisted financially by the public as the programs are produced in the public interest. We feel a sponsored program is well indicated.

ANDREW C. IVY, M.D.
HERBERT Y. H. CHINN, M.D.

Health Education Committee

Your reference committee recommends the acceptance of this committee's report and agrees with the proposal to have sponsored radio and TV programs in order to obtain prime time. The reference committee further recommends the budgeted item of $650 be maintained for this committee.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS COMMITTEE

The HMA PR program was launched just over a year ago, and in the intervening time a basic foundation has been established for a continuing medical public relations effort of increasing effectiveness in the years ahead.

The following is a summary of the work of the PR Committee during the past year:

PR Counselor: Mr. Hugh Lytle has served as PR consultant, press secretary, and executive secretary to the PR Committee since January, 1961. He has faithfully attended all PR planning and action section meetings, as well as membership and key medical committee meetings. He has been accessible at all times for emergency consultation and has effectively implemented many PR projects, issued press releases and produced the weekly HMA radio program "Ask Your Doctor" on KGU. He has visited outer island county medical societies, and attended the AMA PR Institute in Chicago last August.

Planning Section: Weekly meetings of the HMA president-elect, PR Committee chairman, PR counselor, and appropriate section chiefs were held to consider plans and problems and to review progress of projects underway.

Policy Section: A 7-man "action section" of the overall PR Committee has held regular, monthly meetings to determine PR policy, assign and implement projects, and take emergency action when necessary. Several special meetings were held during the HMSA contract controversy and the AAPS essay contest publicity. Members of this important section were Drs. Burden, Giles, Stevens, Arnold, Jr., Richert, Nishigaya, Rose and Chung.

Public Service Section: The HCMS PR Committee has worked in cooperation with the state committee in implementing several important public service projects including civil defense, polio immunization, and the A.M.A. resolutions project, under the chairmanship of Dr. Sloan.

Speakers Bureau: Following an initial period of surveying and screening, over 50 physicians volunteered to serve on the medical association's first speakers bureau under the leadership of Dr. Herbert Pang. Nearly 100 medical speaking engagements were filled, in addition to several informational and training programs featuring

such visiting speakers as Marjorie Shearon, Bishop Kennedy, and William McAuliffe of the A.M.A.

Photo Section: Newly organized in 1961 and headed by Dr. Halpern, the medical association's first official photo team has been on call to pictorialize newsworthy medical events not covered by press photographers. Installation of officers and new HCMS executive secretary Howard Pearce, essay contest awards, civil defense activities, and a feature series on the poison control center were among the events photographed to appear in local newspapers. A national article featuring the ethnic backgrounds of HCMS officers was transmitted through the A.P.

Kokua Samoa: Originated by the PR policy section, a project to furnish medical assistance and personnel to beleaguered American Samoa is underway. Several HMA physicians, headed by Dr. Richert, have served for periods up to a month in a continuing program for which additional physicians are presently volunteering. Governor Lee of Samoa has expressed his gratitude for this much-needed help.

Additional Projects Implemented by the PR Committee: Weekly radio program "Ask Your Doctor," station KGU; Hawaii Association of Professions; annual Press Awards for best medical writing; assistance with TV programs on scientific, economic medicine; annual legislative dinner program; AAPS annual high school essay contest, awards; island-wide cancer society film-lectures; health museum planning; seat belt program planning; East-West Center kokua; prison plastic surgery program; oral polio immunization, Operation Swallow; emergency radio call system, station KORL; U. S. Senate subcommittee hearing on aging; civil defense publicity, newspapers, radio; more than 100 medical news releases; special section *Star-Bulletin* for annual meeting; and A.M.A. resolutions campaign, WHAM.

Recommendations for 1962-63: (1) That vice-chairmen be appointed to assist the over-all PR committee chairman and the chiefs of important sections such as Speakers Bureau, Public Service, and Kokua Samoa. This would provide experienced succession and continuity in key positions. (2) That the $3,000 appropriated from the PR budget to finance legislative committee expenses be restored to the PR program for use in underwriting a monthly series of paid medical ads in the newspapers, as recommended by the A.M.A. (3) That serious consideration be given to the possibility of finding acceptable commercial sponsors to absorb the cost of medical television and radio programs. (4) That a less cumbersome and more liberalized press-medical code be devised to increase medical coverage by the newspapers. (5) That a series of regular "Feedback Forums" be instituted to give key figures in the business, labor, legislative and news media communities a chance to air complaints, explore problems, and share ideas with leaders of the medical profession. (6) That Mr. Hugh Lytle has functioned faithfully and effectively as a PR consultant and his services should be retained.

WILLIAM H. STEVENS, M.D.

Public Relations Committee

Your reference committee recommends the adoption of this report and commends Dr. Stevens and his committee for the many hours of hard work that they have given in our behalf. Your reference committee further recommends that a functioning speakers bureau be established in each of the county societies. Finally, your reference committee recommends that the six recommendations of the public relations committee be accepted.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Richert commented on the second recommendation and explained that it wasn't a matter of refund since there was no transfer. He thought that with the assessment that had been voted for 1963 to cover Legislative Committee expenses a larger portion of the 1963 budget could be allocated to public relations.

PUBLIC RELATIONS COUNSEL

The report of your Public Relations Committee contains an account of planning, public service projects, and other activities of the medical profession in Hawaii.

Speakers bureaus, radio and television programs, press releases, campaigns and such projects as Kokua Samoa, are only a part, however, of the activities aimed at achievement of the long-range goals of what has come to be called "public relations." Some aspects of this work are not unlike the putting out of fires. More important is the creation of conditions not favorable to fires.

A number of physicians have been hard at work at this during the last year. These comparatively few physicians have devoted a disproportionate amount of time in the interest of the profession.

May I respectfully call attention to the report of your legislative committee which asks, with a note of urgency, that physicians in greater numbers take part in community affairs and in politics.

Doctors who do take part in civic affairs and who attend precinct meetings and support the party of their choice, have learned that the results more than compensate for the outlay in time and effort. But these doctors are relatively few in numbers. Until a greater number of physicians take an active and interested part in their own community, the voice of the medical profession cannot be made most effective.

This year is a time of exceptional peril to all of the ethical professions, for the King-Anderson bill now in the Congress is but a prelude to further hoped-for extension of government interference in the professions. That the peril is recognized is apparent from the fact that an Association of the Professions is under study in many states, including Hawaii. If such an association is formed, then the members will have a voice many times more powerful than any one group. But until and unless that association is effected, the professions must speak and act individually. And how effective that may be depends upon the individual.

That is why the recommendation of the legislative committee deserves the most careful scrutiny of every member of the medical profession.

HUGH W. LYTLE

Public Relations Counsel's Report

Your reference committee recommends adoption of this report and commends the work of Mr. Hugh Lytle.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT'S REPORT

The past year was initiated with the establishment of an active public relations program under the general direction of Dr. William Stevens, assisted by Hugh Lytle in the capacity of executive secretary for the committee. Mr. Lytle's most outstanding contribution was the recording and presenting of the "Ask Your Doctor" radio programs. Aside from this, the activities of the committee were primarily carried out by an "Action Committee" under the chairmanship of Dr. Giles.

An attempt was made early in the year to set up a committee on the state level to handle those matters which involved all of the county societies. This program received a setback due to a misunderstanding on the part of a small segment of the society and did not get actively functioning until the AMA requested all states to aid in implementing a program for providing medical care for those over 65 in order to effectively combat the King-Anderson Bill. Although this committee, under the chairmanship of Dr. Hunter, was initiated late in the year, they did an effective job of exploring the problems of initiating a program within the limitations of the premium set by the AMA and Blue Shield. In addition they clearly demonstrated the need for and importance of handling such matters on a state level.

During the current session of the Legislature, just concluded, the activity and efficiency of the Legislative committee, headed by Dr. Liljestrand, was greatly enhanced by engaging Mr. Honda to act as a contact between the members of the committee and the members of the Legislature.

During the year, as your president, I attended the meeting of the AMA in New York, a meeting of WICHE in Salt Lake and a special meeting of the Legislative Section of AMA in Chicago to consider ways and means of helping defeat the King-Anderson Bill. At this latter meeting it was most evident that it was of the greatest importance that each doctor inform himself on the King-Anderson measure and the Kerr-Mills Law, which is currently being implemented, in order to be able to discuss this problem with his friends and patients and to create a better understanding on the part of the general public of the dangers involved by the passage of this bill. It also became evident that, if we are to improve the public image of the medical profession, it is imperative that we as doctors must interest ourselves in general politics and help our neighbors in their fight against socialization if we are to expect outside help in our fight to prevent the socialization of medicine.

As a result of my year in office I would like to make the following recommendations:

1. That the activities of the Legislative committee be further expanded for next year's legislative session and that Mr. Honda, or someone of equal caliber, be retained in the same capacity.

2. That the Medical Care Plans and Fees Committee receive the active support of all county societies and that it be empowered to assume responsibility in all actions involving the entire membership of the Hawaii Medical Association, at the discretion of the president.

3. That serious consideration be given to discontinuing or changing the office of Executive Secretary of the Public Relations committee and that the money thus expended during the past year be expended in other ways more conducive to improving the public image of the medical profession.

The last recommendation is based on two facts. One, that the chief accomplishment of this office was the series of radio programs and it is my feeling that these programs can be continued with the cooperation of the radio staffs, which I feel would be available, and secondly that the money spent on the salary of the executive secretary would be more productive of improved public relations if used in sponsoring a series of newspaper advertisements as outlined by the AMA. This could be and should be carried on at the county level, with the assistance of the state organization by providing matching funds for this project. I believe that this would materially improve relations between the profession and the newspapers and would result in much better coverage of our activities with resultant improved public relations.

It has been a privilege and pleasure to have served as your president during the past year and I urge your utmost cooperation and support of your incoming officers for this coming year, which will be even more critical than the past. Your new president will need the wholehearted cooperation and support of each one of you to successfully carry out the duties of his office.

J. A. Burden, M.D.

President's Report

Your reference committee recommends acceptance without change of the first recommendation contained in the President's Report which relates to the legislative program.

Your reference committee further recommends that the last portion of the second recommendation of this report be deleted and that this recommendation be changed to read: "That the Medical Care Plans and Fees Committee receive the active support of all county societies."

Your reference committee further recommends that the third recommendation outlined in the President's Report be not accepted, and that the recommendations of the Public Relations Committee be substituted instead.

Your reference committee highly commends our President, Dr. Burden, for his long and untiring efforts in our behalf and commends him highly in this regard.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Burden explained that his recommendation relative to the Public Relations Counsel had been made to open the meeting for a thorough discussion. A very good discussion was had and a good solution was arrived at. Dr. Li moved that the last half of the third paragraph of the reference committee report be stricken from the report as not being applicable. The motion was seconded and passed. This portion of the report was adopted as amended.

RESOLUTION NO. 2
RE: SEAT BELTS

Whereas, Scientific investigation has shown that the use of seat belts will reduce by at least 35% the incidence of severe injuries and deaths in automobile accidents; and

Whereas, The House of Delegates and appropriate committees of the American Medical Association have been advocating their use since 1955; and

Whereas, The American Medical Association, the National Safety Council, and the United States Public Health Service for four years have been making a joint effort to popularize the use of seat belts; and

Whereas, All American-made cars beginning with the 1962 models have front seat belt anchorages as standard equipment; and

Whereas, Physicians are looked to by their patients for sound advice on matters of health and accident prevention; therefore be it

Resolved, That the House of Delegates of the Hawaii Medical Association urge every physician in Hawaii to use seat belts in his car or cars, and that the members of the House, members of the Council, and the officers of the Hawaii Medical Association set a good example in this matter by using seat belts in their own cars.

Introduced by:
Richard D. Moore, M.D.

Resolution Re Seat Belts

Your reference committee recommends the adoption of Resolution No. 2 regarding seat belts.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted. The chairman moved adoption of the report as a whole as amended. It was adopted.

INSURANCE AND MEDICAL SERVICE REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your reference committee on Insurance and Medical Service gave careful consideration to the matters referred to it and makes the following report:

CAREERS COMMITTEE

No formal appointments were made to this newly created committee. However, the chairman worked closely with Drs. Sau Ki Wong, John Stephenson, William Dang, Paul Tamura, and Robert Bell in trying to make an outline of the committee's duties and developing methods for implementing its work.

The basic program is now pretty well organized and a pilot program is planned for two schools. We have met with the pre-med students at the University. If these programs are successful in arousing student interest and physician participation, it should be expanded in 1963 to include all major high schools on all the islands.

WILLIAM F. MOORE, M.D.

Careers Committee

Your reference committee recommends acceptance of this report. It is hoped that the committee will expand activities in 1963 to include all major high schools on all the islands. Your reference committee further recommends that this committee be made a subcommittee of the Public Relations Committee.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

CHRONIC ILLNESS AND AGING COMMITTEE

Participation in Activities of State Interim Commission on Aging

The development of action programs in the field of chronic illness and aging continues rapidly in the State under the aegis of the State Interim Commission on Aging. This Committee as a whole has offered its services to the Commission and many members have actively participated in its various committees. Continued interest in the affairs of the Commission would help bridge the gap between the medical profession and the lay community, while the State progresses with the development of a master plan of action programs designed to meet the needs created by the chronic illness and aging problems throughout the nation.

This Committee urges the continued support of the State Commission on Aging's efforts to attain a permanent status and to develop action programs to meet the needs of the aged in Hawaii.

U. S. Senate Subcommittee on Aging Hearings Hawaii, 1961

Dr. Alfred Burden, our president, presented effectively our society's view against the social security approach for the care of the aged. Hugh Lytle prepared the statement assisted by others. Considerable time, sweat and effort went into its preparation. The membership of this association is urged to study the document and prepare to meet any challenge by the proponents of socialized medicine.

My privilege was to present the picture of the Commission's Health Committee and to point out our unified positive approach to the problems of the aged. Your Committee feels that the strongest weapon against socialized medicine is rapid development of strong action programs against chronic diseases.

Participation in State Conferences and Institutes Related to the Aged

The first State Conference for Nursing Home and Care Home Administrators and Staff was held in Honolulu on October 18-19, 1961. The featured theme was "Understanding Our Patients." Over 100 administrators and staff members of nursing homes, care homes and long-term care units of hospitals attended. The conference was sponsored by the Hawaii Nursing Home Association, the Department of Health, and the Commission on Aging. Among the speakers were Drs. Richard Lee, Shoyei Yamauchi, George Stevenson, Nils Larsen, and Fred Shepard.

At the First State Institute on Housing for the Elderly held on November 13-14, 1961, sponsored by the Commission on Aging, Fred Shepard, the dynamic medical director of the Rehabilitation Center of Hawaii, discussed "Health of the Elderly in Relation to Housing,"* which should be read by those interested in this aspect of chronic disease problem.

Coordinated Home Care Program—St. Francis Hospital

Sister Maureen, the able administrator of the St. Francis Hospital, is to be congratulated for rapidly hurdling the initial steps to set up this much needed program in Hawaii. Less than six months after she was asked to serve as the chairman of the Commission on Aging's Home Care Program, the U.S. H.E.W. granted over $160,000 to set up a three-year demonstration study project at the St. Francis Hospital. This Committee is proud to have supported this project.

As the program gets on its way, an informed medical profession and the lay public can help to insure its success. This is a pilot project of utmost importance to bring coordinated comprehensive medical, nursing, and ancillary services into Hawaii's homes. Its success would mean freeing of many hospital beds, and a more satisfying living for many disabled aged with chronic diseases.

This Committee recommends that the HMA continue to support this worthwhile project, by informing its ranks and the people they serve. It is further recommended that HMA acknowledge and commend Sister Maureen for her fine work in bringing into fruition this basic health need for the people of Hawaii. This would create a good public relation for HMA.

Independent Living Project

This pioneering demonstration-study project to bring total rehabilitation to the disabled, now almost 18 months old, and based in a general hospital, is already yielding important administrative guidelines and developing much needed personnel.

A joint meeting with the Health Education Committee heard a comprehensive review of this project on February 9, 1962, from members of the project and Dr. David Frost, N.I.H. representative who helped to give birth to the idea of the project. The total membership of HMA and the general public need to be well informed on this project. Dr. Toru Nishigaya, Dr. Shepard, and other members of this project are to be complimented for a fine job well done.

After a slow start, the project was in full swing by June, 1961. Of the 185 disabled, evaluated by the team, 101 were accepted for therapy on an intensive basis. Sixty-four severely disabled now are able to stay at home or return home after treatment. About half of the remaining 37 are still in the intensive treatment stage. In most cases tremendous progress has been made.

Three of the disabled are working full-time and three others are in work training. Six others will have work potentials.

To evaluate the program, a research formula has been made and goals have been set for each patient to achieve.

This Committee recommends a continued strong support of this project—the first of its kind in the nation. It further recommends that the HMA officially recognize the efforts and fine work done by the leaders and members of this project.

Kerr-Mills Law Implementation

Hearings before this Committee on the MAA programs from representatives of the State Department of Social Services—Mr. Ishida, Dr. Devereux, and Miss Mary Noonan—brought to light many factors confronting the implementation of this law. The reports thus far were based on figures obtained from the first six months of its operation. The impressions gained were that the State Department had moved cautiously and slowly. Liberalization of criteria for acceptance and a more vigorous approach probably are indicated. Health matters could be administrated best by a health oriented agency of the State.

This Committee recommends that continued effort be made to implement the MAA programs in the spirit of the law; to wit, to help the medical indigents by proper legislative support.

* Proceedings of the *Institute On Housing For The Elderly*, obtainable from the Commission on Aging's office, Honolulu, Hawaii.

State Department of Health

The extremely fine cooperation and liaison between this Committee and the State Health Department is a matter of record. In 1951, Dr. Charles Wilbar, then President of the Territorial Department of Health, requested the House of Delegates to create this committee in response to the emerging chronic illness and aging problems. Dr. Richard Lee, the current Director of the State Department of Health, has given during his tenure unqualified support. As of July 1, Dr. Leo Bernstein, an active and a faithful member for the past two years, will take over the helm.

This committee wishes well to both doctors in their newly appointed endeavors and seeks their continued support. Hawaii is fortunate indeed to have two such dedicated men as members of its active citizenry.

This committee proposes that the HMA recognize officially their contributions to health needs of Hawaii and wish them well.

Chronic Illness and Aging Programs
Department of Health

On March 23, 1962, this committee heard a report of the State Health Department's chronic illness and aging programs which were categorized into: (1) Adult Health, involving cancer control programs, heart disease programs, rehabilitation, diabetes, glaucoma and gerontology; (2) Hospitals and medical facilities; and (3) Mental Health Division.

The Department of Health's emphasis is on prevention. The stimulus for the many varied programs appears to have been community interests created by individual chronic diseases. The development, therefore, has been somewhat haphazard and redundant without a definite pattern or an over-all approach.

This committee recommends that a master plan be developed on a unified basis for chronic diseases and aging in the Department. A careful planning and coordination of efforts by this committee and the Health Department is needed. This should be on the agenda of future meetings of this committee. The HMA is requested to endorse and promote this much needed program.

SHOYEI YAMAUCHI, M.D.

Chronic Illness and Aging Committee

Your reference committee recommends acceptance of the report with the deletion of the final sentence in the second paragraph of the section entitled *Chronic Illness and Aging Problem. Department of Health,* to wit "development, therefore, has been somewhat haphazard and redundant without a definite pattern or an over-all approach." The reference committee further recommends that the Secretary of the Association be instructed to write appropriate letters of commendation to Sister Maureen, members of the Independent Living Project, and to the State Department of Health as recommended.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

The annual meeting was held on February 16, 1962, at the Mabel Smyth Building.

This Committee reconsidered a fee schedule for the Crippled Children Section.

A brief background of the Crippled Children Section's fee schedule was outlined.

From 1954 to the present date there has been a separate Crippled Children Section fee schedule that was unrelated to the HMSA or any other fee schedule. At the Advisory Committee meeting of the Crippled Children Section of 1961, the Section suggested 60 per cent of the 1957 Honolulu County Medical Society Relative Value Schedule as a new fee schedule for the Crippled Children Section cases. This suggestion was discussed and passed with one dissenting vote. This minority vote requested that one schedule for all agencies be accepted. The above minority report went to the Honolulu County Medical Society Board of Governors and they upheld the minority opinion. It should be noted, however, that it was not sent to any other county. A report from the Board of Governors of the Honolulu County Medical Society concerning their favorable vote on the minority report was sent to the House of Delegates of the Hawaii Medical Association in May, 1961. The House of Delegates of the Hawaii Medical Association referred the problem back to the Advisory Committee of the Crippled Children Section for further studies. Dr. Burden reported to the Advisory Committee in February, 1962, that the HMA Council had adopted the 1960 California Medical Association Relative Value Schedule on a state-wide basis.

It was recommended that the Crippled Children Section: (1) follow the suggestion to use the CMA 1960 schedule and any changes made in the schedule by the State Medical Care Plans and Fees Committee; and (2) Dr. Edgar meet with this committee in time to get their recommendation on the conversion factor to the House of Delegates.

In reply to the Crippled Children Section's request for a conversion factor for its cases, Dr. Hunter, chairman of the Medical Care Plans and Fees Committee, informed Dr. Edgar that they recommended the following conversion factors be applied to the newly adopted state-wide relative value schedule.

Medical	4.00
Surgical	3.75
Pathology	4.50
Radiology	4.50

In report of the progress on dental fee schedule for the Bureau of Crippled Children it should be noted that dental services are available for cleft palate cases, and to clear up dental infections of cardiac cases.

Dr. Edgar reported that two meetings were held with the State Dental Fee Schedule Committee to discuss fee schedule for the Crippled Children Section. She reported that the American Dental Association did a fee survey of dentists in Hawaii in 1961 and received a 37 per cent reply, which is considered good. The State Dental Fee Schedule Committee was not in agreement with the survey results. The committee came up with a counter-proposal, based on replies of about 40 dentists in the State who participate in the Crippled Children Section programs. At this point it was discovered that the medical care program of the Department of Social Services also has a dental program and they were using the present Crippled Children Section schedule. A meeting was held with Mr. Francis Ishida of the Department of Social Services and Dr. Manuel Kau who is the consultant to their program. They proposed that the Crippled Children Section accept the schedule of the American Dental Association (and the Department of Social Services would adopt the same for indigent children receiving dental care). The State Dental Fee Schedule Committee has not replied to this proposal. No action was possible on the matter.

JOHN P. FRAZER, M.D.

Advisory Committee to the Bureau of Crippled Children

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

EMERGENCY MEDICAL SERVICE COMMITTEE

Five meetings of this committee were held, one of which was a meeting at Berkheimer tunnel with representatives of various organizations for orientation of physicians and dentists assigned to disaster first aid stations. In addition, numerous conferences were conducted between representatives of the committee and the Department of Health.

The Chairman attended a course on Mass Casualty Care at Brooke Army Medical Center, and a conference on the Medical Self-Help Training Program at Alameda, California. Dr. Robert Faus represented the committee at a Civil Defense meeting in Los Angeles.

Hospital Disaster Plans were tested at two major hospitals by the committee and preparation of disaster plans is underway at three smaller hospitals in Honolulu. Many attempts to stimulate interest in disaster planning at Kaiser Hospital proved futile.

The major activity of this committee was the initiation of a training program to organize 44 disaster first aid stations on the Island of Oahu. A training folio, including a teaching curriculum and lecture material, was developed and actual training is completed or underway in six areas. A prerequisite to their activity was the completion of assignments for physicians and paramedical personnel of Oahu. Numerous organizations have been contacted and liaison established with the Red Cross. Publicity included television and radio programs and many press releases.

Planning is underway for a Honolulu city-wide disaster exercise, which will include the first aid stations that have completed their training, as well as the major hospitals. This is expected to be staged in May or June of this year.

Demonstration and testing of a 200-bed CD hospital has been accomplished in Hilo, and is in the organization stage in Honolulu. Similar testing will subsequently be developed for Maui and Kauai.

The committee is also represented in two related statewide programs. One is the Hawaii Emergency Resources Planning Project, now in the task groups study phase. The second is the medical self-help training course, a nationwide project which is depending on doctors for its initial momentum. Also advice and assistance is being given to Honolulu nurses' groups preparing to institute courses in disaster training.

Recommendation for 1962-63 activities of the Hawaii Medical Association in the field of emergency medical services are the following: (1) Continuation of all presently functioning training programs with particular reference to disaster first aid station training. Similar training is advocated for the islands of Kauai, Maui, and Hawaii wherever indicated by population or geographical factors. (2) Institution of a disaster medical care program on an annual basis by each of the county medical societies for one of their regular membership meetings. (3) Expanded support for publicity through all possible news media to stimulate public interest and overcome the present apathy regarding medical preparedness.

EDWARD W. BOONE, M.D.

Emergency Medical Services Committee

Your reference committee recommends acceptance of this report and requests the Secretary of the Association to write a letter of commendation to Dr. Edward W. Boone for his outstanding efforts in this project.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

FEDERAL MEDICAL SERVICES COMMITTEE

This committee met 8 times during the past year to adjudicate claims and to negotiate a fee schedule with the Veterans Administration.

The present Medicare contract will expire August 31, 1962, and the negotiations for a new contract should be undertaken through the joint efforts of this committee and the new HMA committee appointed to work on statewide contracts, the Medical Care Plans and Fees Committee. Two decisions must be made: (1) how we can best convince ODMC in Washington that the present schedule which has been virtually unchanged since 1957 does not represent our 1962 going rates for families with net income under $4500, and (2) the stand the HMA should take if the ODMC requests that the contract be modified to include the provision that no fee schedules for Medicare can be published and distributed among the doctors of Hawaii. Negotiations for the new contract should start immediately and must start, according to the terms of the contract, before June 30, 1962.

Many meetings both formal and informal were held with the new medical director for the Hawaii office of the Veterans Administration, Dr. R. P. Westover. Various members of the committee were assigned certain sections of the fee schedule and asked to compare it to our own RVS, as well as to the HMSA and Medicare schedules. The committee was vehemently opposed to accepting the VA's first proposal to use the August 1, 1959, national Appendix A (their so-called national fee schedule) with a few minor revisions. The committee did, however, accept the VA's ultimatum that the intermediary system for Home Town Care would be discontinued as of June 30, 1962.

The VA Home Town Clinic program was started after the close of World War II when the demands for medical service for veterans were considerably greater than they are now. The VA was approached for changes in the fee schedule during the 1946-1956 period. The first approach to get the VA program on our own RVS was made February 8, 1957. On March 6, 1957, the VA advised "... this office will be glad to consider the recommended revision (of the fee schedule) which in all probability will be based upon the relative value concept. In principle, this appears to be a sound approach to establishing equitable fees...." On March 8, 1957, the HMA asked that the current RVS be used with the following conversion factors: Medicine, 400; Surgery, 428; Radiology and Pathology, 500. On March 27, 1957, Dr. Zink of the VA advised that although he felt the RVS approach was satisfactory, it contained many items which are not eligible benefits under the VA program and submitted a VA schedule for approval, which was forwarded on April 12. They set May 1 as the deadline for return of the fee schedule. A sixty-day extension was requested and the HMA was advised that the fee schedule was not required in the execution of the new contract. Prior to this time the VA was advised that the HMA was following its RVS in billing the VA. On May 16, 1957, Dr. Middleton disagreed with Dr. Zink about the application of the RVS for the VA contract and advised that funds for the ensuing year would not allow revision of the schedule. He advised that there were approximately 40 services which are commonly authorized in the program for Hawaii and asked that we submit a schedule for these procedures only and added that the relative value concept could be used in arriving at fees deemed appropriate for Hawaii. Our letter dated May 27, 1957, advised that there was great objection on the part of the GP's to the government's designating specialists. The schedule was accepted with the deletion of the words "and specialty if applicable" and one procedure. Because of the problem regarding specialists and the fact the VA advised their budget had already been allotted no changes were made in the 1946 fee schedule, although a copy of the most commonly used procedures in Hawaii was submitted.

Failing to get an increase in fees for the 1957-58 fiscal year the committee asked for a specific deadline in order to avoid running up against VA's budgetary problems. A schedule was submitted on December 6, 1957. The VA indicated that the 1946 schedule was out of line but that the RVS did not necessarily mean that such fees were being charged in the community, especially on the neighbor islands. They were firm in their stand to pay no more than the "going rate." The local office's medical director was asked to make his own survey. On April 23, 1958, the VA submitted a fee schedule, and advised it was the maximum that could be allowed. They asked for approval prior to May 15. The fees were protested on May 7. On June 3 a few adjustments were allowed and approval was deemed necessary by June 10. We advised that the adjustments were not satisfactory and asked that the National Fee Schedule be allowed with a 20%

upcharge to cover the cost of living difference in Hawaii. The 20% figure was used because it is the amount of differential allowed in the Federal employees pay scale. On June 20 the VA turned down this proposal because the budget for the ensuing year was already set and asked for immediate execution of the schedule, which had been slightly adjusted. On June 23 the revised fee schedule was reluctantly agreed to.

In July of 1958 the committee met with Dr. C. H. Francis of the VA office in San Francisco who offered to help with our problems. He advised that if we could establish our median or average charge for similar service, we would strengthen the support for future proposed fees. Negotiations for the 1958-59 fiscal year were begun in November of 1958. The committee decided to try to get increases in fees in the short form (the 40 most commonly performed procedures) and ask for the RVS schedule for the balance. On November 21, 1958, the short form with increases asked the previous year but not granted was submitted with the request for the RVS for the balance. This was submitted through Dr. Francis. Minor adjustments were allowed in the short format and the inadequate fees were reluctantly accepted. The VA agreed that the RVS would be used for procedures not listed, except that "no higher fee for any rendered service can be authorized than such generally charged in the community." HMSA was requested to attach that portion of the VA letter referring to their acceptance of the RVS to each schedule at the time the schedules were mailed to the physicians. This was done in the form of a memorandum to all physicians dated June 15, 1959.

No negotiation for changes in the contract for the 1960-61 or 1961-62 fiscal years were carried out.

Negotiations for the 1962-63 contract were begun in November, 1961. The VA asked that the 1959 National Appendix A be used with some minor changes, but the committee insisted that a more realistic fee schedule be adopted. At this time it was discovered that although we thought we were operating on the RVS for all except 40 items, the HMSA on its own authority had signed contracts which did not include this provision. Dr. Westover sent our revisions, which were made on the VA form and which represented the RVS fees with certain downward modifications, on to Washington. The schedule was forwarded in February. On April 11 the VA in Honolulu addressed the following letter to the HMA:

> The proposed medical fee schedule submitted by you has been sent to Central Office, Washington, D. C., for their consideration and approval.
>
> They have replied as follows:
>
> "Due to the fact that the 1963 fiscal year budget was established almost one year ago, it will be impossible to approve the proposed increase as of July 1, 1962. This problem is nationwide and almost $1,000,000.00 has been included in the FY 1964 budget beginning July 1, 1963, to cover this increase. We may assure you that the major portion of the fee schedule as submitted by HMSA will be approved for use as of July 1, 1963.
>
> "In the meantime, i.e., July 1, 1962-1963, will you please request their consideration of the attached revised DM&S Appendix A fee schedule."
>
> Since I have no alternative but to adopt the above fee schedule on July 1, 1962, and since it is an increase in many items over the present fee schedule, I am asking your consideration and approval of this schedule.

The schedule submitted deletes the following statement in the contract "An exception to the fees listed may be made, however, in individual cases by the Chief Medical Director of the VA if undue complications are met or when other extenuating circumstances prevail." Furthermore, with only three exceptions (office visit from $4 to $4.50, allergy survey from $40 to $75, and cystoscopy from $35 to $50) there appear to be no increases to the fee schedule in effect for the last three years. Above the surgery and pathology sections the following is written "Fees to be approved by the Clinic Director. This schedule does not apply."

The committee did not have time to meet as a body before this report was submitted. Those members who were consulted expressed disappointment but not surprise at the VA's ultimatum. The committee is reluctant to recommend accepting a contract which pays $10 for a night house call, a fee that remains unchanged since the first VA contract was signed in 1946. This procedure is listed as $12.50 in the 1959 VA schedule for California, a state where the Federal employees do not receive a 20% tax-free bonus to compensate for higher living costs.

GROVER H. BATTEN, M.D.

Federal Medical Service Committee

Your reference committee recommends acceptance of this report with emphasis on the committee's recommendation that an immediate study of the present Medicare contract which will be up for negotiation in the near future be initiated, and that the committee study the question of whether or not the fee schedule should be published.

Your reference committee recommends that the proposed fee schedule of the Veterans Administration, referred to as Appendix A, not be accepted.

Your committee further recommends that the present Federal Medical Service Committee be retained with Dr. Batten as chairman, and that this committee be made a subcommittee of the Medical Care Plans and Fees Committee.

ACTION:

The chairman advised that he wished to insert the following between the third and fourth paragraphs of his reference committee's report: "Your reference committee recommends that negotiations for a fee schedule with the Veterans Administration for the fiscal year 1963-64 be initiated immediately, and that the chairman of this committee be requested to write a letter to Dr. Westover for dates of congressional meetings on budgets and the deadline for submission of a fee schedule prior to these dates. The perennial problem of the State Association in obtaining a fair fee schedule also to be mentioned in this letter, copies of which will be sent to the congressmen from Hawaii." The chairman moved adoption of this portion of the report as corrected. Dr. Waite questioned the propriety of using the name of the individual who is at the present time the director and suggested that his title be substituted. Dr. Mills questioned the validity of making this a subcommittee without changing the Bylaws. The parliamentarian advised that if the House wished to recommend that this matter be referred to the Bylaws and Parliamentary Committee, this could be done. Dr. Burden noted that when he appointed the members of the Medical Care Plans and Fees Committee he included Dr. Batten because he was chairman of the Federal Medical Services Committee and he felt this committee should have representation on the Medical Care Plans and Fees Committee. Dr. Lum moved that the matter of making the Federal Medical Services Committee a subcommittee be referred to the Bylaws and Parliamentary Committee the motion passed. The original motion as corrected and amended was passed.

HOSPITAL LIAISON COMMITTEE

There have been four meetings of the Hospital Liaison Committee in the past 12 months. During these meetings we concerned ourselves with fundamental problems of good medical care. These meetings were attended by representatives from hospitals, insurance industry, and medicine.

Early in the year progressive patient care was discussed. It was brought to the attention of this committee that the subject should be divided into three parts—intensive care, progressive care, and self care. The reason for the great interest in this program is its possible use in decreasing the cost of hospitalization and providing more beds for acutely ill patients. There is some doubt that the actual cost of hospital care will be decreased with this program. It is also pointed out that in order for this type of program to be workable, hospital facilities must be constructed with this idea in mind. The patients and physicians must likewise be educated to accept this change.

Hospital utilization was discussed with representatives from hospitals and insurance industry. The local Blue Shield program and representatives from commercial companies agree that there is no great misuse of hospital benefits. If there is any problem it would involve only the one- or two-day prolongation of stay. An educational program beamed at unions, patients, industry, insurance companies, and docotrs would be the most acceptable way to try to keep hospitalization at a minimum. A strong policing policy was not accepted as the correct approach.

The Hawaii Hospital Association with the support of the State Department of Health and the Hawaii Medical Association will conduct a state-wide survey to determine the present status of hospital facilities. Through this survey we hope to be able to determine for long-range planning the type of hospital that is needed, the equipment, the facilities, and the service. We also hope to ascertain the habits of the community in hospital utilization. Through this means, a stable long-range program may be developed which will provide data to be used to build only those hospital beds that are needed where they are needed, decreasing duplication and cost to the public.

It is recommended that:

1. Further study be done by a subcommittee to determine and make available to those who are interested the true picture of progressive patient care.
2. Hospital utilization problems be approached through education and not through policing policies.
3. The Hawaii Medical Association continue its full support of the hospital survey study of the Hawaii Hospital Association.
4. This committee be continued as a permanent committee of the Hawaii Medical Association so that continued liaison between the physicians and hospitals may be kept on a high plane.

GEORGE H. MILLS, M.D.

Hospital Liaison Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MEDICAL CARE PLANS AND FEES COMMITTEE

This committee met seven times since it was formed in February. It was originally known as the "Negotiating Committee" but objections to that name were raised and its present name adopted on March 14. Neighbor island members participated in most of the meetings and all their expenses, except the dinner expense which was paid by the HMA on authority of the President, were paid for by their county societies. This is an innovation and it is the hope of this chairman that closer liaison between the counties will be beneficial and promote better understanding of the problems that face the profession today.

The committee was charged with three tasks: (1) To develop a fee schedule for the Bureau of Crippled Children. (2) To develop a plan to be sold through the HMSA for the over-65 people of Hawaii. (3) To arrive at conversion factors for the national Blue Shield plan proposed for the low-income, over-65 group. The first task was completed, the second held in abeyance awaiting outcome of the third, and the third task was the cause of many long hours of debate at all seven meetings.

The committee recommends to the House of Delegates for approval that the 1962-63 fee schedule for the Bureau of Crippled Children be based on the Hawaii Medical Association's Relative Schedule using the following conversion factors: Medicine, 4; surgery, 3.75; radiology, 4.50; and pathology, 4.50. It should be noted that these are the conversion factors used by the Honolulu Foundation for Medical Care for their Plan II which is devised for persons whose family income is between $3,000 and $6,000. The Bureau's paitents are all either indigent or medically indigent. The fees that result from using these conversion factors were compared to those now being used in California. California's fees are based on similar conversion factors but on the 1957 RVS instead of the 1960 (which is identical to Hawaii's RVS), but they anticipate changing to the 1960 RVS in a matter of weeks. The proposed changes are the first to be made in the program since 1954.

Although the committee has not concentrated on the local over-65 plan yet, at a meeting with Joe Veltmann and Albert Yuen our wishes were made known. We asked them to work out a plan for the over-age under income group on the 1960 RVS. They are working on a plan for the over-65 on the $7200 income level. For this plan the 1960 RVS at a conversion factor of 5 should be used, while it is proposed that 80% of that amount be used for the low income group.

The committee is indebted to two of its members, Drs. Mills and Lum, for the comprehensive analysis made on the National Blue Shield's Physicians' Service Index, known without much affection as PSI. This relative value study was made in order that the National Blue Shield accounts could be serviced. The relativity is a composite of fees taken from forms processed by Blue Shield plans in all the states. Upon examination it was determined that it is not possible to compare PSI relativity to our own RVS.

After many debates it was voted to recommend to the House of Delegates that the Hawaii Medical Association participate in the National Blue Shield over-65 plan for one contract year by using an across-the-board fee schedule based on our own relative value study with the following conversion factors: Medicine, 4; Surgery, 2.25; Radiology, 4; and Pathology, 4. It should be noted that this plan has service benefits only for those falling within the income limits—not more than $2500 for a single person and not more than $4000 for a couple. The conversion factors selected are the same as those used in Honolulu Foundation's Plan I, which is designed for people whose total family incomes range from zero to $3,000. The RVS used by the Foundation is almost identical to the HMA's RVS.

There were many arguments for and against adoption of this plan. The arguments for accepting any national plan include: (1) It is important to offer a national plan before the King-Anderson bill goes up for a vote, presumably some time late in May. (2) This is an important propaganda tool and Hawaii cannot afford not to participate. (3) The plan will have little local appeal and will not sell. (4) Probably only about 2,000 of our 29,162 senior citizens would be eligible to purchase the plan. (5) Forty plans have already accepted the PSI with varying conversion factors.

Arguments against accepting the plan include: (1) It is not a good plan. (2) It is poorly designed to meet the needs of this age group. (3) It plays into the hands of the proponents of Social Security medicine. (4) It sets a precedent. (5) It will generate overutilization of hospital beds.

It should be noted that the plan offers full service surgical benefits. Diagnostic benefits are limited to inhospital care. Medicine is limited to inhospital benefits at stated rates for the first, second, and subsequent hospital visits.

No consultation is allowed. They originally proposed to allow prolonged detention care at an hourly rate but it is almost certain that this will be withdrawn in favor of offering inhospital intensive care at stated rates for the first day, second day, and third through 14th days.

The arguments for accepting the PSI include: (1) This is what is being offered. (2) It will help the National Blue Shield actuaries figure the lowest possible premiums. Arguments against using the PSI include: (1) It cannot be compared to our own RVS. (2) The Medical Services Section cannot be converted at any figure which would reflect going rates in Hawaii; i.e., the hospital visit units are 7.5 for the first day, 5 for the second, and 2.5 for subsequent days. No matter what conversion factors are used, the relativity is out of balance. (3) This is just one more fee schedule and the HMA is desirous of reducing its present number (17) of schedules and attain a better degree of uniformity.

The arguments that the National Blue Shield organization will not accept the proposed offer include: (1) Other states have accepted PSI across the board. (2) They want a uniform nationwide schedule.

Arguments that National Blue Shield will accept the proposal are that the fees will be lower than those in states accepting the PSI at the median rate of conversion (1.3 for medicine, 3 for surgery, and 4 for pathology and radiology). (2) California will undoubtedly be allowed to use its RVS (which is the same as Hawaii's) at the same conversion factor they use in their schedule for the care of the indigents, 4 across the board.

Concern about the surgical conversion factor has been expressed since it is designed for incomes less than those in the national plan. There is some question whether this figure is realistic even for the income group it is supposed to cover.

Another problem of considerable magnitude is the establishment of a going rate. Medical benefits have never been on a service basis and it is not possible to determine an accurate going rate for these procedures without a comprehensive and valid survey. The rule of thumb indicated for this plan is that the individual plans use fees that are 80% of those charged for medicine pathology, and radiology, and 60% of the surgical schedule. It is estimated that 65% of the claims processed for this plan will be for medical benefits. If it could be validly established that the conversion factor of 5 across the board is the going rate, as is commonly believed, the suggested conversion factors would be 4 for everything except surgery and 3 for surgery.

The National Blue Shield organization has indicated a willingness, even an eagerness, to accept firm figures for the medical portion, rather than conversion factors. They have indicated that they would like Hawaii to agree to hospital visit rates at the 4, 3, 3, level and intensive care at the 15, 10, 5 level. They indicate that actuaries estimate the average length of stay will be 14 days and it is the total package they will consider. Using our proposed rate of 4, the hospital visits will amount to $6, $4, and $4. We do not have listed values for intensive medical care. National Blue Shield has indicated that most of the care rendered in the hospital will be classified as intensive.

The only item in the medicine section of PSI which is comparable to our RVS is consultation requiring limited examination of a given system but not requiring a complete diagnostic history and examination, home, office, or hospital. This is 3 units in the RVS and 10 units in PSI. Using the normal conversion factor of 5 the dollar value under RVS is $15. In order to make the dollar value the same under PSI a conversion factor of 1.5 has to be used. To decrease both conversion factors by 80%, you reach 4 under RVS and 1.2 under PSI. Using 1.2 on PSI and assuming that intensive medical care will be substituted for prolonged detention care, and converting at the 1.2 rate (which is the lowest rate being adopted by any of the 40 plans which have agreed to use PSI) you get

First day of Intensive Care Rendered
15 units × 1.2 = $18.00

Second day of Intensive Care Rendered
10 units × 1.2 $12.00

Third day of Intensive Care Rendered
5 units × 1.2 $6.00

It is not known what California plans to use for this part of the program since they do not have comparable procedures in their schedule.

The committee wishes to call the House of Delegates attention to the definition of "going rate." In simplest language, it is the fee level that most local physicians stay at or below.

The committee recommends that the Hawaii Medical Association go along with the philosophy of the proposed Blue Shield plan, and further that the HMSA be requested to ask permission from the National Association of Blue Shield Plans to use Hawaii's RVS for the nationwide, over-65 plan.

This committee was formed to work with and devise statewide fee schedules when such are required. It is the feeling of the committee that knowledge of the problems attendant about such duties can be gained only through experience and that the make-up of the committee should not be changed except that the policy of asking each county president to appoint one representative to the committee be retained.

ROBERT G. HUNTER, M.D.

Medical Care Plans and Fees Committee

Your reference committee makes the following recommendations:

1. That the Hawaii Medical Association agree to the philosophy of the National Blue Shield Plan for the over-age, under-income group.
2. That the Hawaii Medical Association request HMSA to inform the National Association of Blue Shield Plans that the Hawaii Medical Association will use Hawaii's 1960 Relative Value Schedule with the following conversion factors: 4 for medicine, 3 for surgery, 4 for radiology, and 4 for pathology, with portions of the medical section rewritten because of minor changes.
3. That the Hawaii Medical Association request HMSA to formulate a plan which will be more comprehensive, and will more closely meet the local needs, and that this plan be restricted to those over-65 with a single income of $2,500 and a combined income of $4,000, using as a basis the 1960 Relative Value Schedule of the Hawaii Medical Association.
4. Your reference committee also recommends approval of the Hawaii 1960 Relative Value Schedule for use by the Bureau of Crippled Children with the following conversion factors: Medicine, 4.00; Surgery, 3.75; Radiology, 4.50; and Pathology, 4.50.
5. Your reference committee recommends that the Hawaii Medical Association conduct a relative value and cost survey in order that we can more accurately determine the usual charges for these services in this State.
6. Your reference committee further recommends that the Medical Care Plans and Fees Committee study the feasibility of combining the recommended National Blue Shield Plan for the aged, as outlined above, with a hospitalization plan based on the use of State or Kerr-Mills funds to subsidize hospital premiums in the indigent and medical indigent aged group.

ACTION:

The chairman moved adoption of this portion of the report. Dr. Burden noted that the recommendations of the reference committee followed those of the standing committee. Dr. Mills moved that the first paragraph be amended by changing the words "over-age, under-income" to "over-65, low-income." The motion was seconded and passed. Dr. Mills moved that the word "only" be inserted in the second paragraph between the words "use" and "Hawaii's" and that the last four words of this paragraph be deleted and the fol-

lowing substituted "to specifically include first and subsequent days of care, intensive care, nursing home care, and concurrent care," and that the words "approves in principle" be inserted in the sixth paragraph after the word "further." Dr. Lichter questioned the difference in conversion factors between plans and questioned the lack of relativity. Dr. Mills explained the basis for the reduction and noted that the overhead expenses for the different specialties varied somewhat and are generally estimated to be about 50% for radiologists, 60% for pathologists, 40% for internists, and 30% for surgeons. The motion was seconded and passed.

The third and fourth portions of the report were voted on and passed.

Dr. Giles asked where the money to conduct a survey was to come from. Dr. Lum advised that the reference committee had no recommendations on that but understood that the state association has some funds that might be used for this survey. Dr. Burden said this was a matter for the Council. Dr. Giles noted that there had been considerable discussion on this and the thing that held up the survey was its cost, the estimates being $5,000 and $15,000. Dr. Burden said that if the House approves of this, the Council will have to wrestle with the financing. Dr. Waite noted that the American College of Surgeons is in the process of conducting a study of this kind and he felt that when this is completed, that portion which is applicable, will be available to the Association. He was thanked for this information.

Dr. Burden asked Dr. Giles to take over the chair while he discussed the last portion of the reference committee report. Dr. Burden said he recommended the approval of the AMA plan as an answer to the King-Anderson bill. As such it is a very weak answer unless we include this portion of the report. The philosophy of program has been accepted. The combined premium for the national Blue Shield program combined with the Blue Cross program will be about $14 or $15 a person, which is a high premium for persons in this income bracket. He felt this would give the opposition a chance to say these people cannot afford the premium and the people need King-Anderson. Also Blue Cross passed a recommendation to the effect that they didn't care how their program was financed. They felt it would have to be financed by some government agency, and they didn't care whether it was State, Social Security, or what. We say we have Kerr-Mills and don't need King-Anderson. If we recommend this plan to utilize Kerr-Mills, we will be backing up our position. Dr. Cushnie said we had committed ourselves to Kerr-Mills and asked what would happen if this is changed. Dr. Burden said we already have Kerr-Mills. It was moved to accept the sixth recommendation of this portion of the report with the insertion of the words "approves in principle and" between the words "Committee" and "study." The amendment was passed.

Dr. Mills rose to move additions to the report and the parliamentarian ruled that these additions should be taken up under "new business."

The chairman moved adoption of this portion of the report as amended. It was adopted.

RESOLUTION NO. 1
RE: STATEWIDE RELATIVE VALUE STUDIES

WHEREAS, A Relative Value Study is an effective means of providing a sound statistical basis for the many indemnity and service fee schedules used by insurance companies, unions, industry and Federal and State government agencies; and

WHEREAS, No appreciable change in fees by prepaid programs for surgery has been made since 1956, and none in medicine since 1938 and these obsolete values have been incorrectly accepted as a reflection of the "going rate" in the community; and

WHEREAS, The American Medical Association encourages Relative Value Studies on a *statewide* basis; and

WHEREAS, There is little significant difference among the counties to warrant more than one Relative Value Study; and

WHEREAS, The American Medical Association looks upon various health insurance and prepayment programs as mechanisms that the people can use to assist them in discharging their responsibilities in paying for their health service; and

WHEREAS, The California Relative Value Study has been adopted by the Hawaii Medical Association; and

WHEREAS, Certain modifications in the California Relative Value Study may be needed to reflect the practice of medicine in Hawaii; and

WHEREAS, A statewide Relative Value Study will strengthen voluntary health insurance and make all schedules used in paying for physician services more realistic, uniform, and therefore more acceptable; now therefore be it

Resolved, That

(1) The Hawaii Medical Association commence immediately to prepare a survey to determine any adjustment necessary in the California Relative Value Study as revised in 1960 to make it appropriate for an up-to-date statewide Relative Value Study,

(2) This survey be conducted by person or persons trained and qualified to conduct such a survey,

(3) The Treasurer of the Hawaii Medical Association be authorized to appropriate moneys for said survey,

(4) The Hawaii Medical Association encourage each component County Medical Society to adopt the completed Relative Value Study,

(5) The Hawaii Medical Association encourage each County Medical Society to adopt their own appropriate conversion factor or factors to be applied to the Study which will reflect the "going rate" in that county when requested for various governmental or service programs, and

(6) This endeavor not be construed as an attempt to in any way to set fees, increase fees, nor raise the cost of medical care in Hawaii, but is rather a sincere attempt to reflect the true cost of medical care in Hawaii.

Introduced by:
GEORGE H. MILLS, M.D.

Resolution No. 1: Statewide Relative Value Study

Your reference committee strongly recommends acceptance of this resolution.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

The chairman moved adoption of the report as a whole as amended. It was adopted.

A 10-minute recess was declared.

Dr. Bergin asked the chair to change the order of business and to call for the election at this point in order that the Hawaii delegate might catch the 4:15 plane.

ACTION:

Dr. Bergin moved that the rules be suspended and the report of the Nominating Committee be voted upon. The motion was seconded and unanimously passed.

NOMINATING COMMITTEE

In the absence of the chairman, the Secretary read the Nominating Committee's Report as follows:

The Nominating Committee consisting of Drs. H. L. Arnold, Jr., E. K. Chung-Hoon, E. F. Cushnie and T. Nishigaya met at 4:30 P.M. January 16, 1962, in the ex-

ecutive offices of the Hawaii Medical Association to select nominees for the offices of president-elect, secretary, and one councilor each from Hawaii, Honolulu, and Kauai counties.

It was the recommendation of the Hawaii County Medical Society that Dr. Robert Miyamoto be selected to fill Dr. Bergin's unexpired term as councilor from their society. The Kauai County Medical Society recommended Dr. Burt O. Wade as their selection for councilor from their society. In accordance with custom and tradition the Nominating Committee unanimously accepted these recommendations.

With a desire to develop as fine a group of nominees as was possible the committee reviewed, studied, and discussed the qualifications of many candidates. The Nominating Committee is now pleased to present the following slate of nominees for your consideration:

President-Elect.....*Rodney T. West, M.D.*
Secretary.....*Samuel D. Allison, M.D.*
Councilor from
Hawaii County.....*Robert Miyamoto, M.D.*
Councilor from
Honolulu County.....*Chew Mung Lum, M.D.*
Councilor from
Kauai County.....*Burt O. Wade, M.D.*

All nominees have been contacted and they have accepted the nominations.

EDWIN K. CHUNG-HOON, M.D.

ACTION:

Dr. Bergin spoke for the Nominating Committee's selection for president-elect, and moved that the nominations be closed and the Secretary be instructed to cast a unanimous ballot. The chair ruled that this could not be done. Dr. William Dang nominated Dr. O. D. Pinkerton for the position of President-elect. Dr. Wipperman moved that the nominations for the offices of Secretary, Treasurer, and Councilors be closed and the Secretary be instructed to cast a unanimous ballot for these men. The motion was passed. The polls were closed and Drs. Thomas Richert and James Fleming were appointed tellers. The chair announced that Dr. Rodney T. West had won the election for the office of President-elect.

UNFINISHED BUSINESS

The first item to be considered under unfinished business was the report of the Hawaii County Medical Society, which was not received in time to be sent to a reference committee.

ACTION:

Dr. Morgan moved that this report be referred to the Council for action. The motion was seconded and passed.

NEW BUSINESS

The first item to be considered under new business was the assessment proposed by the Legislative Committee and accepted by the Reference Committee on Parliamentary Affairs. Dr. Liljestrand spoke for this assessment.

ACTION:

Dr. Liljestrand moved that the House of Delegates approve an assessment of $22 a member for 1963. Dr. West noted that if the House allowed the Council to make an assessment up to $22 to cover the legislative activities the assessment would be open to change. The maker of the motion accepted the suggestion and changed his motion to read that the Council be authorized to make an assessment up to $22 for one year, 1963, to cover the Legislative Committee's activities. The motion was seconded and passed with three dissenting votes.

Dr. Mills asked for the floor to introduce two motions. The chair noted that there had to be a unanimous vote to permit the introduction of new business at this point.

ACTION:

Dr. Giles moved that Dr. Mills be permitted to present his motions. The motion was seconded and unanimously passed.

Dr. Mills said the reason for asking for acceptance of additional proposals was that our present fee schedule may be under or over and it would be of great help to the Association to learn the going rates in the community.

ACTION:

Dr. Mills moved that the Hawaii Medical Association urge all physicians to bill their normal fees on all fee claims regardless of any commitment on fee schedules. If there was prior commitment, then the physician should make any needed adjustment in his bill after payment is received from the insurance company. The motion was seconded and passed.

Dr. Mills moved that the Hawaii Medical Association request HMSA to immediately undertake plans to convert the basis of its fee schedules to the 1960 Hawaii Relative Value Study inasmuch as this study more truly reflects the practice of medicine in Hawaii, and that appropriate conversion factors be established after conference between HMSA and HMA. Dr. Warshauer asked if anesthesia were included and was advised affirmatively. Dr. Burden asked about the date. Dr. Mills replied, "Immediately." Dr. Burden questioned whether this would be financially feasible. Dr. Lichter said not with a three million dollar reserve. The motion was seconded and passed.

Dr. West asked for the floor. He said he realized that he was a controversial figure and wanted to assure those that had doubts about his capacity that he would always take into consideration the wishes of the majority of the members and would work for the betterment of the Association as a whole.

Dr. Lichter asked that the election of Dr. West be made unanimous and was advised by the parliamentarian that this could not be done.

The meeting recessed until evening.

At 7:00 P.M. the President gave his address and introduced the new officers. The remarks of the new President were postponed until Saturday evening.

RODNEY T. WEST, M.D.
Secretary

The 107th Annual Meeting of the Hawaii Medical Association will be held in Honolulu

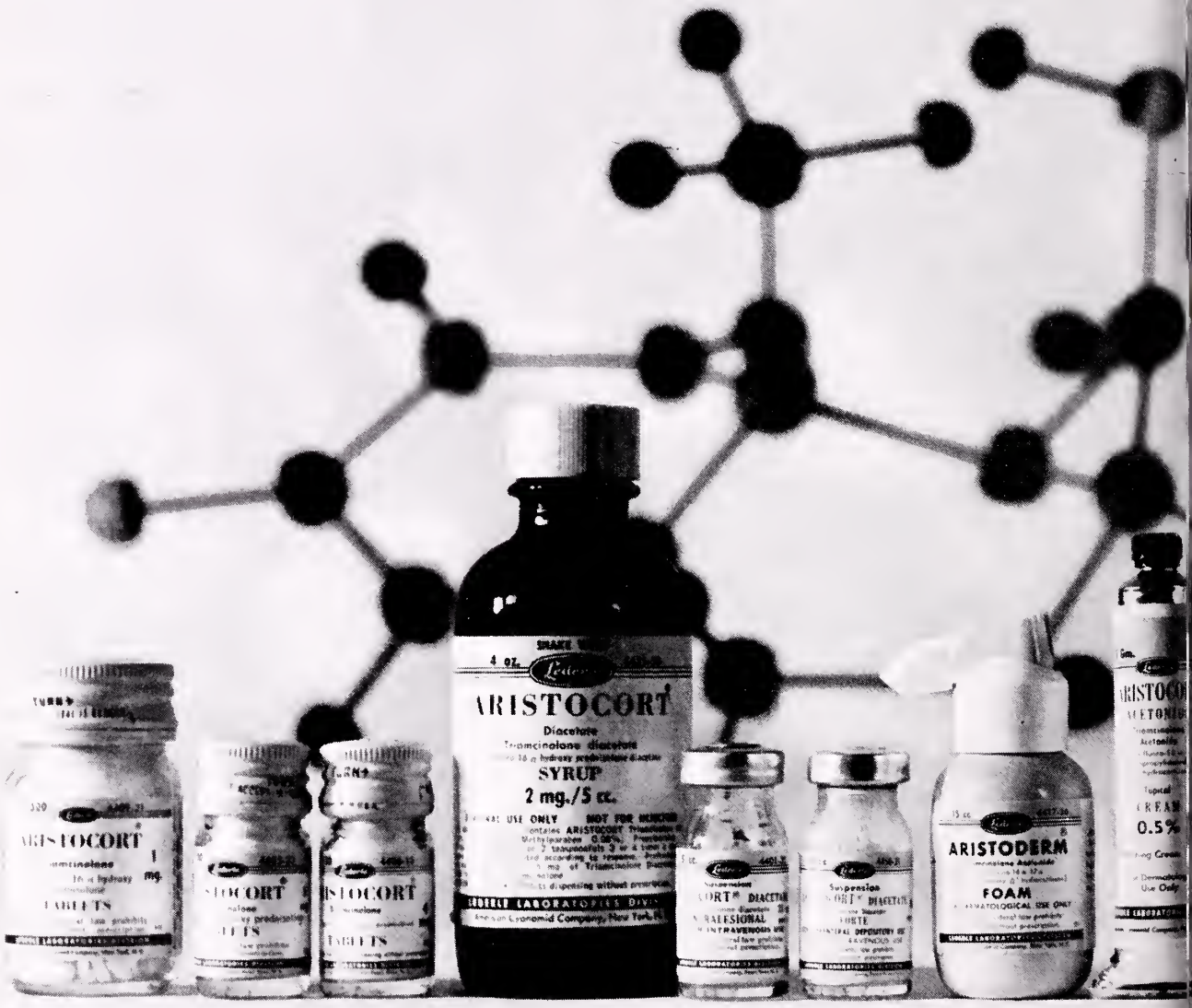
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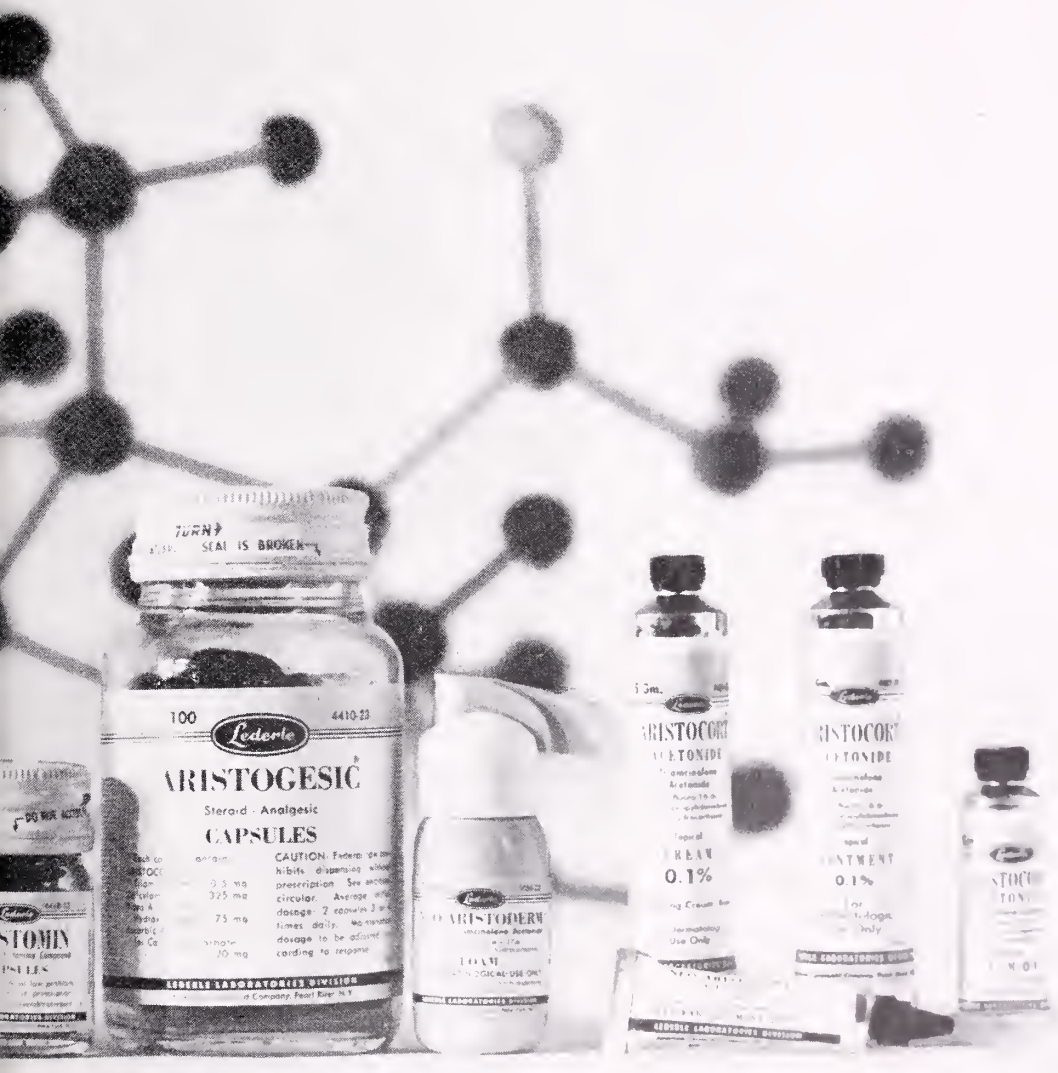
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Official Publication of the Hawaii Society of Medical Technologists

BERYL UYEHARA, *Editor* MAX BOWMAN, *Associate Editor*

*Some Common Problems Encountered in Blood Banking**

C. R. MACPHERSON, M.D., *Director*
Blood Bank, University Hospital
Ohio State University, Columbus, Ohio

The number and type of problems encountered will depend to some extent on the volume of blood handled, but more important, it will vary with the type of patient. A high proportion of people who have had multiple transfusions, and a large obstetrical service, will always mean large numbers of problem patients compared with the bank which does not deal with such patients. In any bank, however, large or small, problems come up from time to time. The present report is based upon both the problems which we have encountered in the University Hospital over the past few years and those which have been referred from other hospitals.

Many of the problems are actually not blood banking problems, but arise from inadequate technique. The most important is undoubtedly unsatisfactory glassware. This falls into two main categories: The first is the etched tube which is clean but which has been used too often. The second is the tube which may be new but which nevertheless is not clean. Both of these will cause false positives, that is, apparent agglutination which is impossible to distinguish from the real thing. The same effect can also arise from the use of contaminated serum from a specimen which has been spun down too soon after collection. This gives rise to "serum clots," and these may be a great source of difficulty. Many of the problems can be solved by insisting upon scrupulously clean glassware. If glassware shows any trace of grease pencil, it is probably too dirty. If it shows more than a trace of etching on the bottom, it has been used for too long. Contamination can be avoided but the "serum clot" or "fibrin clot" is more difficult since it is most likely to arise in those cases where one has the least time, namely, in emergencies. There is at present no easy answer to this problem.

If one excludes rather nonspecific problems, difficulties can be divided into four broad groups. Surprisingly, by far the most common is the problem of the questionable ABO tvping. Occasionally, of course, these are of the frank error type, namely calling an "A" a "B" or an "O" an "AB," but a number are due to the inherent inability of some antigens in this system to react in a clear-cut and specific way with the available typing sera. The most obvious example of this problem, of course, is the weak variant of the "A" antigen which goes by a variety of names, depending upon the degree of reactivity—A_2, A_3, A_4, and so forth. Fortunately, with the exception of A_2, these weak variants are quite uncommon. This is, of course, no excuse for missing them. Especially since the results may be quite disastrous. In our experience, there are two techniques which will assist materially in picking up these weak variants. First, the reverse type using patient's serum and known "A" and "B" cells. This in turn implies a tube typing method. Although we employ both, if one is unable to do both, then we feel that the tube type is preferable. The second technique is the use of group "O" serum. This is used to type all cells which appear to be group "O". Group "O" serum reacts much more avidly with the weak "A" variants than do the normal anti-A typing sera and virtually all such variants will be picked if this technique is employed. We feel, therefore, that the minimum ABO typing involves tube-typing using both known anti-A and anti-B sera and known A and B cells. In addition, group "O" serum should be used to check all apparent group "O" patients and donors.

PROBLEMS IN RH TYPING

The second area in which problems not infrequently arise is in Rh typing. Here again, whether to use the tube or slide method is debatable, and points in favor of both can well be made. Where possible, we feel that both techniques should be employed. But again if it is possible to use only one, the tube technique is better for the simple reason that this can be combined with the use of a high protein control. This control is of the utmost importance in detecting false positive reactions which are due to the presence of excessive rouleau formation. This in turn is associated with abnormalities of the protein content, most classieally with multiple myeloma. It must be emphasized that this pseudoagglutination is indistinguishable from the real thing by either technique, slide or tube, and can be distinguished only when a high protein control is used. Problems connected with the Rh variant D^u are well known, but it cannot be too often emphasized that all apparently Rh negative donors should routinely be screened for D^u.

Connected with the cross match itself, problems arise in one of two ways. The first is the occurrence

of specific agglutinins in the sera of patients who have been transfused before, or who have been pregnant. However, naturally-occurring antibodies rarely will cause problems. This type of problem, although baffling when first encountered, is solved quite easily once the antibody has been identified. When this has been done, the problem consists simply of the provision of blood lacking the factor against which the antibody is directed. With specific typing serum used for the preliminary screening of donor units instead of the patient's own serum this may be a somewhat tedious procedure, but it involves no real difficulty. However, until the antibody is identified, this may be an extremely difficult problem where the antigen involved is one of high frequency; for example, factor e (hr″). In the last example of this type of antibody encountered, the patient required eight units of blood, and we had to type just over 300 units in order to find eight which lacked this factor. Using commercial typing serum for this purpose rather than screening with the patient's serum (by doing multiple cross matches) is much easier, and also saves the patient multiple venipunctures. We can thus say that specific antibodies interfering with cross matches do so only until they have been identified. After that they do not represent much of a problem.

"COLD AGGLUTININS"

The second type of problem encountered in the cross match is in many ways a much more trying and difficult one. This is the pan-agglutinin, usually of the "cold" type. These antibodies may represent a very serious problem if they are present in high titer and are very avid. One normally thinks of a "cold agglutinin" as being an antibody which will agglutinate cells suspended in saline at 4° C. This is not altogether true since a high titer antibody will usually be active at room temperature, and frequently at 37° also. An additional cause of confusion is the fact that many of these enzymes are used, but may not show any activity against cells suspended in saline. The problem when these are encountered in the cross match is to recognize them and at the same time exclude the possibility of any specific antibody's being present. The reason for doing this is that with very rare exceptions, "cold agglutinins" do not cause any significant transfusion reaction, while specific antibodies normally are expected to cause a significant or even fatal reaction.

There are a number of techniques by which the "cold agglutinins" may be by-passed and a compatible cross match obtained. The simplest is washing of the cells prior to performing the anti-human globulin (Coombs') test with 37° saline, rather than room temperature saline. This will often abolish the reaction and give a negative cross match. In some stubborn cases, it may be necessary to have all of the glassware and the centrifuge basket warmed, and to use six 56° saline washes. This, however, is a technique which can be applied only with caution since there is always the theoretical possibility of eluting a weak specific antibody by this rather vigorous treatment. A second technique which has been widely applied is the technique of absorbing the serum with the patient's own cells. This can be applied only where the patient has not recently been transfused. If transfused cells are still circulating, one may absorb out specific as well as nonspecific agglutinins. Another technique which may be employed is simply that of waiting since many "cold agglutinins" lose their activity on overnight storage at 4° C. This loss of activity on storage is also responsible for some of the discrepancies between the problems encountered in the initial hospital and the lack of any problem found in the referring laboratory. Many "cold agglutinins" will not survive an overnight trip by air or any other method of transportation.

Only too often, however, the urgency of the problem does not allow this method of solution. In such cases, the only technique which is sometimes of assistance is that by which the patient's cells are cross matched against the patient's own serum. If this shows an incompatibility which is as great as is seen between the patient's serum and the donor's cells, then one sometimes has to assume that this denotes simply a nonspecific agglutinin of no real importance. This technique is certainly not recommended except in cases of desperation, since it is not uncommon for a "cold agglutinin" to mask the presence of a specific agglutinin. In such cases, the best solution is to have a good reference laboratory available where one can go in an emergency.

CONCLUSION

In conclusion, one should again emphasize what has been emphasized so often before; namely, that in blood banking there is seldom any justification for doing anything other than the maximum, the best, and the most sensitive procedure. It is often stated that one cannot afford to do some of these procedures. The alternative viewpoint is that one cannot afford to eliminate these procedures if they afford real protection to the patient. The secret and essence of good blood banking is to be able to distinguish between the procedures which can be eliminated and those which cannot. Whatever technique is employed, however, there can be no compromise about the care and the skill with which it is carried out. ●

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INDEX TO VOLUME 21

Subject and Title Index

A

Abdominal pain, puzzling types of 38
Adrenal adenoma, left, primary hyperaldosteronism due to 410
Anemia, pernicious, laboratory findings aiding in the diagnosis of 354
Antibiotic treatment of staphylococcal disease 495
Artificial kidney
  experiences with at The Queen's Hospital 131
  "nephromime" indications 125
Asterol dihydrochloride toxicity 342

B

Balnei granuloma, "swimming pool" disease, some characteristics of in Hawaii 403
Biliary tract and liver function testing 144
Blood bank
  some common problems encountered in 164
  prove and improve your 164
Book reviews 59, 153, 245, 348, 431, 509

C

Coagulation time, venous 72
Contact lenses 36
Correspondence 301, 514
County Society Reports 62, 152, 246, 346, 428, 511

D

Deafness, recent advances in surgery for 221
Doctors of Hawaii—In Memoriam
  Bull, Charles George 506
  Durney, Charles Paul 58
  Foote, Gilbert A 424
  Furry, John Delarma 244
  Gaspar, Luiz Rodriques 244
  Hagan, Martin 151
  Hugus, H. P. 506
  Patterson, Lawrence Leslie 424
  Palmer, John Williamson 345
  Shepard, Irwin James 151
  Shipley, George T 244
  Thompson, James Malcolm 244
  Troutman, Holmes Fielding 345
  Waterhouse, Alfred Herbert 58
Duodenal ulcer, perforated, in a premature infant with survival 141

E

Editorials
  Aloha, nurses! 241
  AMPAC 240
  Balnei granuloma in Hawaii 422
  Birth defects 423
  Glue sniffing 505
  Hawaii birth rate 241
  Our "new hat" 341
  Medical discipline 52
  Medication by government fiat 148
  National Foundation for everything! 53
  No hurry about oral polio vaccine 147
  No more scruples 148
  Nurses support the King bill 54
  Social Security medicine 341
  Service concept and Social Security, the 505
  William Hillebrand 340
Electromyography and electrical stimulation 492
Encephalitis, meningo-, a new parasitic disease of man in Hawaii 139
Experiences with the artificial kidney at The Queen's Hospital 131

F

Fetal death, gas formation in fetal circulation as evidence of 417

G

Gas formation in fetal circulation as evidence of fetal death 417

H

Hawaii Medical Association 60, 247, 350, 519
Hawaii Technologists' Bulletin 72, 164, 262, 354, 438, 550
Hearing and speech, the school health evaluation project 227
Heart disease, rheumatic, and rheumatic fever in University of Hawaii Freshmen 234
Hyperaldosteronism, primary, due to left adrenal adenoma 410
Hyperparathyroidism 43
Hyperthyroidism, primary 499

I

Infant research 419
In Memoriam—Doctors of Hawaii 58, 151, 244, 345, 424, 506
Inter-Island Nurses' Bulletin 66, 158, 254

K

Kerr-Mills vs King-Anderson 327, 338
Kidney
  artificial, experiences with the, at The Queen's Hospital 131
  artificial, "nephromime" indications 125
King-Anderson
  bill, what's wrong with the 332
  vs Kerr-Mills 327, 338

L

Laboratory findings aiding in the diagnosis of untreated pernicious anemia 354
Lead poisoning 427
Liver and biliary tract function testing 144

M

Meningo-encephalitis in Hawaii, a new parasitic disease of man 139
Microchemical methods, problems related to reproduction of 438

N

"Nephromime," artificial kidney, indications 125
New Members 347, 429, 510
Notes and News 61, 154, 248, 349, 430, 512

O

Obituaries
Glaser, Frank E. 248
Gordon, Maurice 513
Kushi, Edward S. 155
Kusunoki, Clarence Junro 154
Kutsunai, Toshio 249
Wynn, William Henry 349
Observations on staphylococcus aureus phage-type 80/81 Hawaii and its resistance to antibiotics 262
Oligophrenia, phenylpyruvic 413

P

Parasitic meningo-encephalitis in Hawaii, a new parasitic disease of man 139
Perforated duodenal ulcer in a premature infant with survival 141
Pernicious anemia, laboratory findings aiding in the diagnosis of 354
Phenylpyruvic oligophrenia 413
Poison reports 57, 342, 427
Pregnancy, skin diseases affected by 41
Premature infant, perforated duodenal ulcer in, with survival 141
Presidential address 526
President's Page 49, 146, 238, 337, 421, 504
Primary hyperaldosteronism due to left adrenal adenoma 410
Primary hyperthyroidism 499
Problems relative to the reproduction of micro-chemical methods 438
Puzzling types of abdominal pain 38

R

Recent advances in surgery for deafness 221
Reports and Snorts 214, 321, 398, 482
Rheumatic Fever and rheumatic heart disease in University of Hawaii Freshmen 234

S

Sarcoidosis in Hawaii: why doesn't it occur? 33
School health services evaluation project: speech and hearing 227
Skin diseases affected by pregnancy 41
Some characteristics of "swimming pool" disease in Hawaii 403
Speech and hearing: the school health evaluation project 227
Staphylococcal disease, antibiotic treatment of 495
Staphylococcus aureus, observations on, phage type 80/81 Hawaii and its resistance to antibiotics 262
Surgery for deafness, recent advances in 221
"Swimming pool" disease in Hawaii, some characteristics of 403

T

This Is What's New! 55, 149, 243, 343, 425, 507
Trichinosis 230

U

Ulcer, perforated duodenal, in a premature infant with survival 141
University of Hawaii freshmen, rheumatic fever and rheumatic heart disease in 234

V

Venous coagulation time 72
Victory for reason or emotion, a 487

W

What's wrong with the King-Anderson bill? 332

Author Index

Alicata, Joseph E. 139
Alvarez, Walter C. 38
Ambrose, John 499
Arnold, Harry L., Jr. 41
Bracher, George 417
Brown, Donald W. 33
Burden, J. A. 332, 490
Cabot, Nancy T. 327
Chang, Walter Y. M. 141
Civin, W. Harold 125
Crowell, David H. 419
Devereux, Dorothy Ann 354
Dito, William 230
Edgar, Katherine J. 227
Ferrell, Carl B. 438
Foster, Amy 227
Frissell, Thomas P. 36
Garis, George B. 43
Gilbert, Fred I., Jr. 410
Hess, Donald 72
Higaki, M. 403
Ho, Richard K. B. 57, 342, 427
Horio, Shigeru Richard 131, 139
Joy, Robert J. T. 230
Larson, Leonard W. 487
Malootian, Ida 164
MacPherson, C. R. 550
McBride, Thomas C. 234
Miller, Frank L. 230
Miyashiro, James S. 499
Moo, Jen Fong 227
Nordyke, Robert A. 144
Ogata, J. 403
Okihiro, Michael M. 492
Pang, L. Q. 221
Powell, Renee 227
Schwartz, Stephen L. 499
Scuff, Jack J., Jr. 499
Shinn, M. F. 403
Spicer, Robert A. 227
Tabrah, Frank 413
Tamura, Paul Y. 125
Tanimoto, R. H. 262
Torin, D. E. 495
Walker, Hastings H. 403
Warden, Horace 141

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Notes and News *continued from 513*

Drs. Varian Sloan, John Felix, Walter Ozawa, and **K. C. Chock** were busy in Las Vegas at the AAGP Convention. We wonder how busy and where???

Dr. T. W. Kanda got a tremendous plug from a local columnist (Bob Krauss) for his beautiful gardens and orchids on Maui.

Dr. Donald W. Brown will do postgraduate work in Tennessee. He left in July and will be gone a year.

Dr. Masato Mitsuda left recently with his family for Seattle and to Los Angeles and Disneyland to enjoy a vacation with the kids.

Other doctors off to the AMA in Chicago are: **Sam Wallis, H. Q. Pang, Walter Chung, Richard Moore, Elmer Johnson, George Mills, Fred Giles, Varian Sloan,** and **Henry Dickson.**

Dr. Morton Berk is back from Boston, New York, and Washington, D. C.

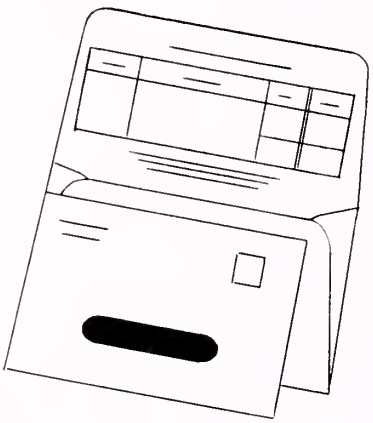
Dr. and Mrs. Rodney West took off in July for a vacation in South America.

Hawaii Doctors in Print

Dr. Joseph E. Strode's paper on "Stomal Obstruction Following Gastric Resection" was published by the *Archives of Surgery* in their December issue. **Dr. Ralph B. Cloward** wrote "Simple Dislocation of the Cervical Spine. Treatment by Vertebral Body Fusion" for the *Western Journal of Surgery, Obstetrics & Gynecology*. The November-December bulletin of the Pan-Pacific Surgical Association contained a special message from its Director General, **Dr. F. J. Pinkerton.**

continued page 558

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Notes and News *continued from 556*

The *Archives of Otolaryngology* published **Dr. L. Q. Pang's** paper on "Bronchoscopy Under General Anesthesia" in its April issue. **Dr. Raid Chappell** was one of the authors whose "Meninogoencephalitis By A Metastrongylid Lung-Worm of Rats" appeared in the February 24, 1962, issue of the *JAMA*. **Dr. Harry L. Arnold, Jr.'s** report of "Dysesthesia in Alopecia Mucinosa" appeared in the March issue of *Archives of Dermatology*. **Dr. Carl H. Lum** was co-author of a paper on "Thymic Cyst of the Neck Simulating Goiter," which was published last April in *Surgery*. **Dr. Ivar J. Larsen's** literary contribution "Smile A While" was on page 218 of the May 5 *JAMA*.

Obituary

The profession suffered another great loss recently when long-time practitioner **Dr. Maurice Gordon** passed away.

Condolences to **Dr. Milton Traeger** who recently lost his wife.

Dr. Harry H. Blodgett, who practised in Hawaii before moving to Beverly Hills in 1927, died December 28, 1961, at Newport Beach, Calif.

Bulletins

The dates for the next Pan Pacific Surgical Association meeting are November 5 to 13, 1963. The Princess Kaiulani will again be the headquarters hotel.

College of General Practitioners will meet in Sydney in October, 1963, and has invited Hawaii doctors to register. ●

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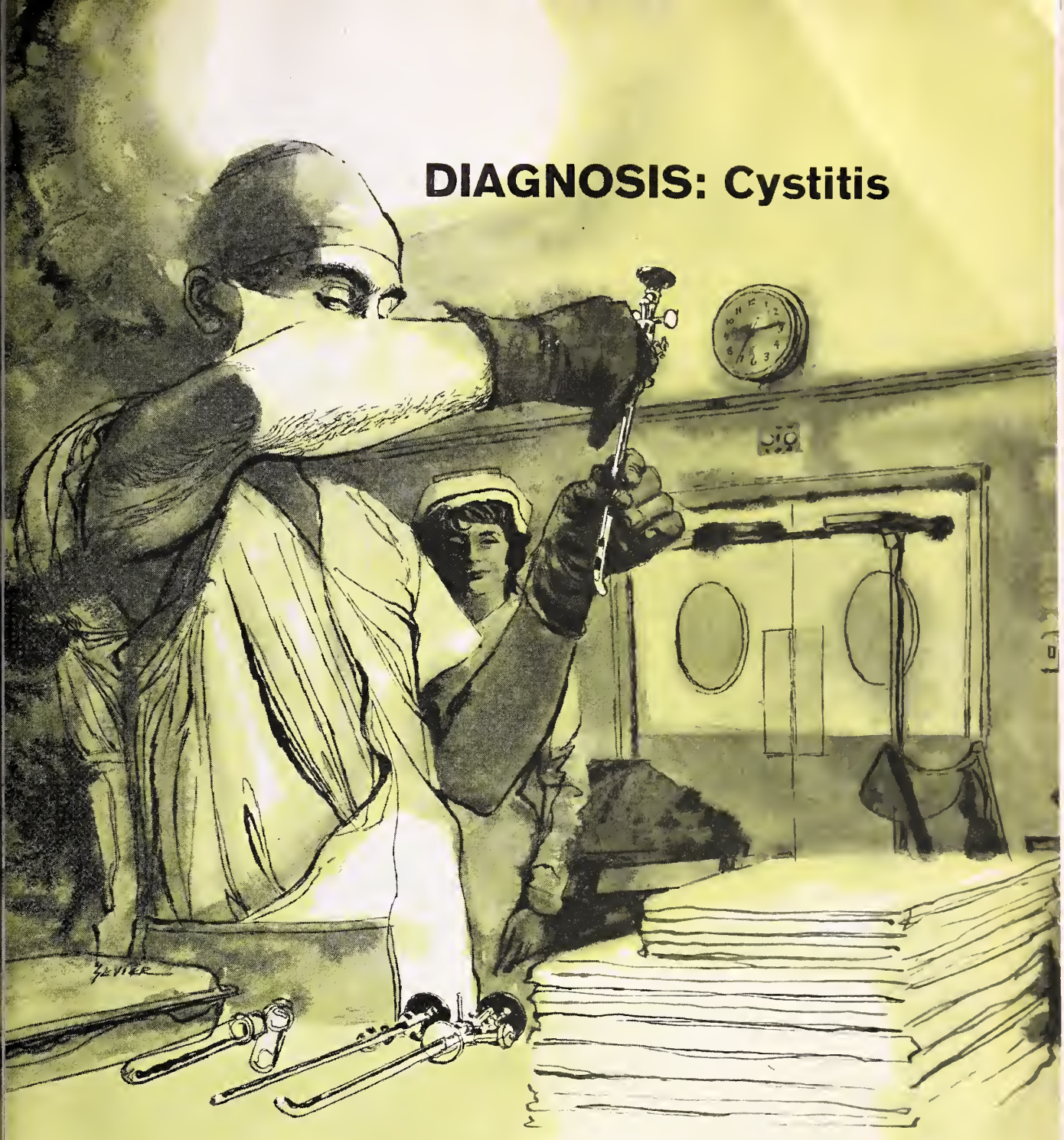
By the same reasoning that a Doctor cannot tell his Patient to take "medicine," it must be a prescribed formula, skillfully blended, to effect a cure, neither can a Doctor accept just *any available method* and expect it to "cure" his bookkeeping problems.

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Book Reviews *continued from 509*

The Future of Psychiatry

Edited by Paul H. Hoch, M.D., and Joseph Zubin, Ph.D., 271 pp., $8.75, Grune & Stratton, Inc., 1962.

A LOOK into the future by a score of contributors. For psychiatrists.

Pediatric Clinics of North America, Vol. 9, No. 2

Nathan B. Talbot, M.D., Editor, pp. 323-520, W. B. Saunders Co., May, 1962.

A GROUP of qualified physicians report on recent advances in knowledge concerning the pathophysiology of disease of importance to those concerned with the care of children.

The Medical Clinics of North America, Vol. 46, No. 3

LeRoy H. Sloan, M.D., and Ford K. Hick, M.D., Guest Editors, pp. 601-883, W. B. Saunders Co., May, 1962.

TWENTY-NINE contributors present a symposium which emphasizes the importance of simple techniques in diagnosis.

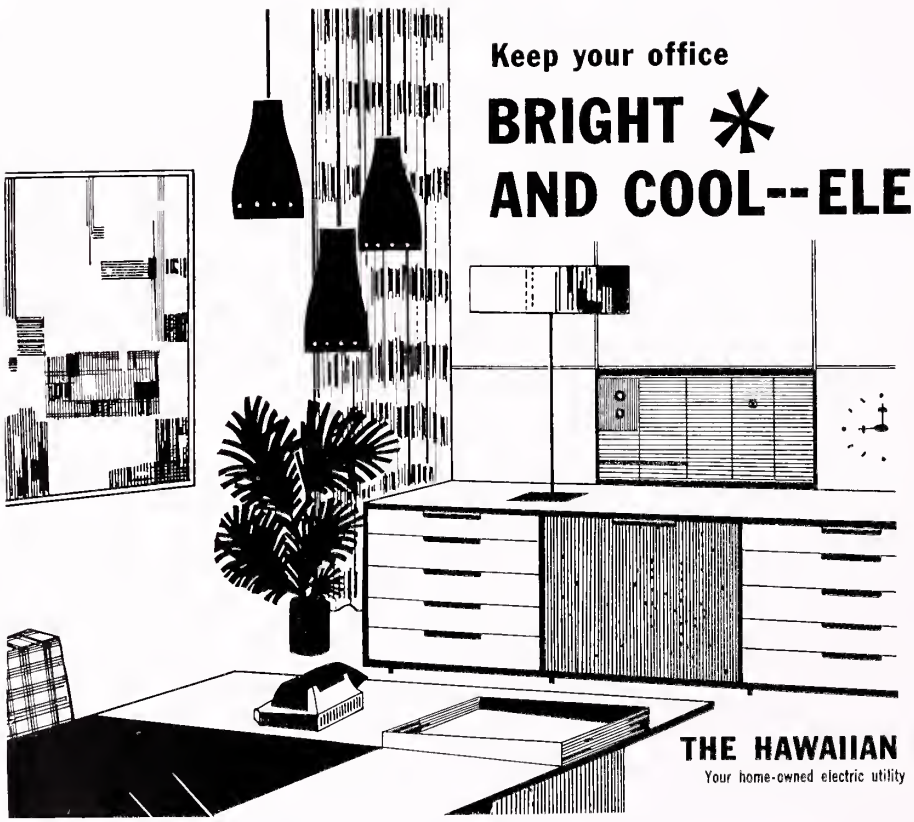
Internal Medicine in World War II, Vol. I, Activities of Medical Consultants

Editor in Chief, Colonel John Boyd Coates, Jr., M.D., 880 pp., $7.50, U. S. Government Printing Office, 1961.

OF GREAT historical interest. The discussion of venereal disease in Hawaii is remarkably sketchy.

continued page 562

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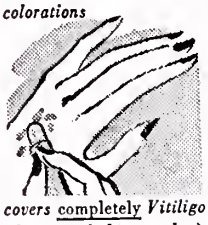


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Book Reviews *continued from 560*

The Medical Clinics of North America, Vol. 46, No. 2

Benjamin B. Wells, M.D., Ph.D., Marc J. Musser, M.D., and Robert J. McClaughry, M.D., Guest Editors, pp. 307-600, W. B. Saunders Company, March, 1962.

SYMPOSIUM on the management of medical emergencies by 38 contributors. Veterans Administration Hospital number.

Pediatric Clinics of North America, Vol. 9, No. 1

Lee Forrest Hill, M.D., Editor, pp. 1-322, W. B. Saunders Company, February, 1962.

SYMPOSIUM by 31 contributors on medical emergencies.

Surgery of the Ambulatory Child

By S. Frank Redo, 340 pp., $8.50, Appleton-Century-Crofts, Inc., 1961.

VERY BASIC. Three pages of pictures showing how to put on gown and gloves.

Practical Management of the Obese Patient

By Frank L. Bigsby, M.D., and Cayetano Muniz, M.D., 151 pp., $4.00, Intercontinental Medical Book Corporation, 1962.

FIFTEEN kinds of obesity and practical advice on their management.

Hallucinations

Edited by Louis Jolyon West, M.D., 295 pp., $9.75, Grune & Stratton, Inc., 1962.

A VERY CLOSE look. For psychiatrists.

continued page 564

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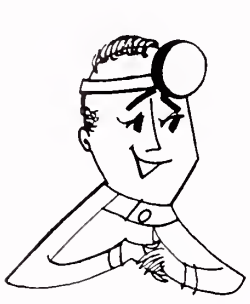
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Book Reviews *continued from 562*

Psychotherapeutic Techniques in Medicine

By Michael and Enid Balint, 236 pp., $4.50, Charles C. Thomas, Publisher, 1962.

FOR GENERALISTS, though they are not likely to take the trouble to read it.

Night Calls—A Study in General Practice

By Max B. Clyne, M.D., with an additional chapter by Aaron Lask, 216 pp., $4.50, Charles C. Thomas, Publisher, 1962.

PSYCHIATRIC ASPECTS of night calls. For psychiatrists—though oriented generalists might enjoy it too.

★Ciba Foundation Symposium on Renal Biopsy

G. E. W. Wolstenholme and Margaret P. Cameron, Editors, 395 pp., $10.50, Little Brown and Company, 1961.

THIRTEEN symposia with 29 participants from six countries, and verbatim discussions. A valuable reference work. Liberally illustrated.

Manual of Practical Micro and General Procedures in Clinical Chemistry

By Samuel Meites, Ph.D., and Willard R. Faulkner, Ph.D., 354 pp., $11.50, Charles C. Thomas, Publisher, 1962.

CLINICAL pathologists will no doubt want to own this up-to-date volume by biochemists from Ohio State University and the Cleveland Clinic.

continued page 566

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1. Dupler, D.A., Greenwood, R.J., and Connell, J.T.: J.A.M.A. 174:123 (Sept. 10) 1960.
2. Hobbs, L.F.: To be published. 2/3026MB

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Book Reviews *continued from 564*

Milieu Therapy in Schizophrenia

By Lieutenant Colonel Kenneth L. Artiss, MC, 169 pp., $6.00, Grune & Stratton, Inc., 1962.

FOR INSTITUTIONAL psychiatrists primarily. An account of an experiment.

Pharmacology and Therapeutics

By Arthur Grollman, Ph.D., M.D., 1131 pp., $12.50, Lea & Febiger, 1962.

FOURTH EDITION in 1960—fifth in 1962! This is primarily for medical students rather than physicians—but a useful reference work nonetheless. The author is both a pharmacologist and a respected, practicing internist.

Higher Cerebral Functions and Their Clinical Disorders

By Benno Schlesinger, M.D., 560 pp., $14.75, Grune & Stratton, 1962.

WECHSLER SAYS in his preface that the author has "set a rich table" (i.e., food for thought!) for the neurologist, the psychologist, and the psychiatrist. One wishes one had time as well as appetite for such a meal.

Physiology of Strength

By Theodor Hettinger, M.D., 84 pp., $4.50, Charles C. Thomas, Publisher, 1961.

ONE-THIRD of the maximum strength of a muscle, exerted for 10-20 per cent of the period required to completely fatigue it, produces the maximum obtainable training effect! "PE" might be made pleasanter if teachers know this.

Irritation and Counter Irritation

By Adolphe D. Jonas, M.D., 367 pp., $7.50, Vantage Press, 1962.

THE "autoamputative property of the nervous system"—a new and intriguing hypothesis about mental "illness."

Annals of the New York Academy of Sciences, Vol. 96, Art. 1

D. V. Siv Sankar, Conference Editor, Franklin N. Furness, Editor, 1-490 pp., The New York Academy of Sciences, January, 1962.

THIS SERIES of papers on biological aspects of schizophrenic behavior is the result of a New York Academy of Sciences Conference held on April 6-8, 1961. One hundred six contributors.

Annals of the New York Academy of Sciences, Vol. 96, Art. 2

Ethel Boissevain, Conference Editor, Franklin N. Furness, Editor, 491-679 pp., The New York Academy of Sciences, January, 1962.

THIS SERIES of papers is the result of a conference entitled "Anthropology and Africa Today" held by The New York Academy of Sciences May 1-3, 1961. Fifteen contributors.

Annals of the New York Academy of Sciences, Vol. 96, Art. 3

Ernest Harms, Conference Editor, Franklin N. Furness, Editor, 680-894 pp., The New York Academy of Sciences, January, 1962.

THIS SERIES of papers is the result of a conference on "Fundamentals of Psychology: The Psychology of the Self" held by The New York Academy of Sciences on May 11 and 12, 1961. Fourteen contributors.

continued page 568

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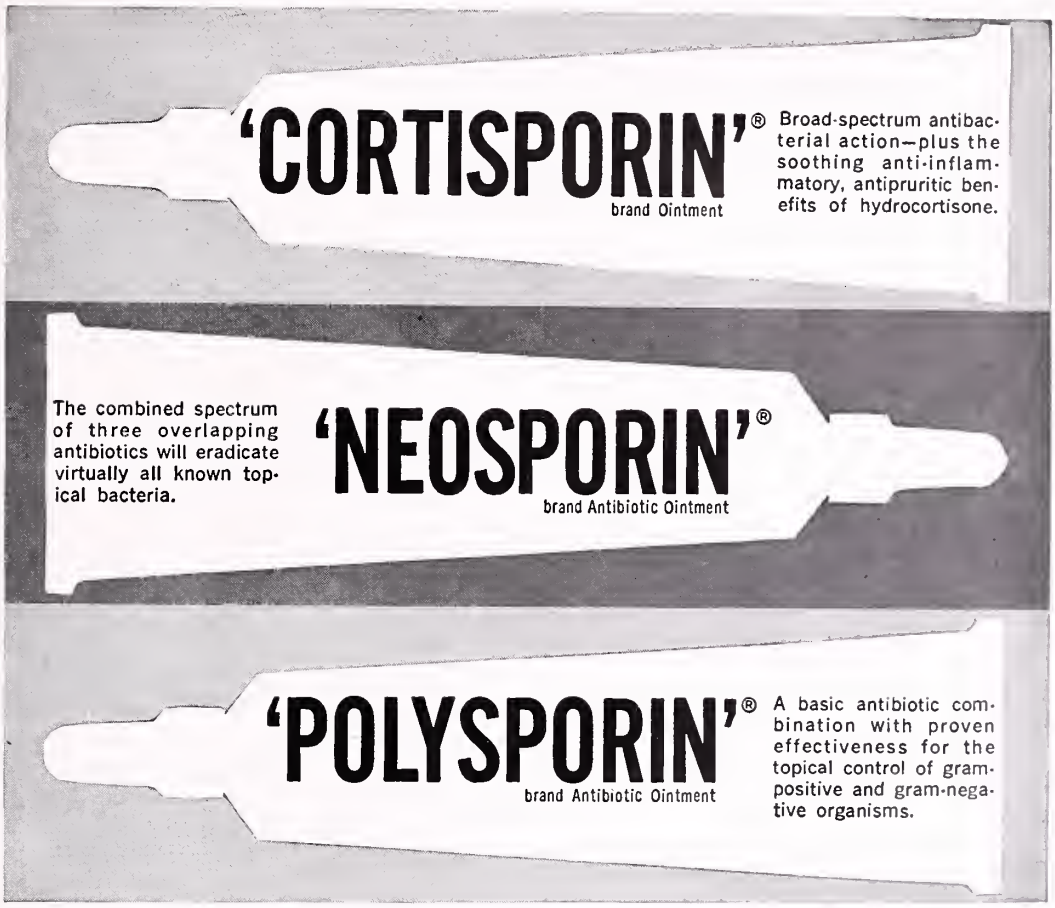
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Book Reviews *continued from 566*

Postpartum Psychiatric Problems

By James Alexander Hamilton, Ph.D., M.D., 156 pp., $6.85, The C. V. Mosby Co., 1962.

OBSTETRICIANS would profit by reading this.

The Physiology and Pathology of Leukocytes

Edited by Herbert Braunsteiner, M.D., and Dorothea Zucker-Franklin, M.D., 293 pp., $15.00, Grune & Stratton, Inc., 1962.

FOR HEMATOLOGISTS. Pretty deep, but beautifully presented.

New and Nonofficial Drugs

Evaluated by A.M.A. Council on Drugs, 900 pp., $4.00, J. B. Lippincott Company, 1962.

THE USUAL encyclopedic little volume, one of the AMA's finest services to the medical profession. It should be far more widely read.

Modern Concepts of Hospital Administration

Edited by Joseph Karlton Owen, Ph.D., and Robert K. Eisleben, M.A., 823 pp., $16.00, W. B. Saunders Company, 1962.

DOCTORS INVOLVED in governing hospitals would do well to own this beautifully produced, clearly written, well-illustrated volume.

★Thalassemia

By Robin M. Bannerman, M.A., D.M., M.R.C.P., 138 pp., $6.50, Grune & Stratton, 1961.

AUTHORITATIVE, exhaustive, clearly presented account of "the thalassemias."

continued page 570

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Book Reviews *continued from 568*

The Mechanism of Action of Water-soluble Vitamins (Ciba Foundation Study Group II)

Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, 120 pp., Little, Brown and Company, 1962.

AUTHORITATIVE and deep. Not for the average practitioner.

Somatic Stability in the Newly Born

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A., 393 pp., $10.00, Little, Brown and Co., 1961.

PEDIATRICIANS would find this well worth their time. Deep, though.

Medicine and the Navy, 1200-1900, Vol. III

By Christopher Lloyd, F.R.Hist.S., and Jack L. S. Coulter, F.R.C.S., 402 pp., $10.00, The Williams & Wilkins Co., 1961.

SEVEN HUNDRED YEARS of history—one hundred of them in this volume—through the eyes of Navy doctors. Fascinating!

Clinical Obstetrics and Gynecology, Vol. 5, No. 1

Edited by Roger B. Scott, M.D., 320 pp., Paul B. Hoeber, Inc., March, 1962.

TWO SYMPOSIA—one on the newborn and the other on office gynecology.

★Shock—Pathogenesis and Therapy

U. S. von Euler, Symposium Chairman, edited by K. D. Bock, 387 pp., $13.00, Springer-Verlag, 1962.

THIRTY-ONE articles by 41 contributors, with verbatim discussions. Excellent, but not for light reading.

Clinical Immunology and Allergy

By Leo H. Criep, M.D., 582 pp., $18.75, Grune & Stratton, Inc., 1962.

AUTHORITATIVE, beautifully printed, liberally illustrated, and practical.

Progress in Hematology, Vol. III

Edited by Leandro M. Tocantins, M.D., 384 pp., $16.50, Grune & Stratton, Inc., 1962.

ONLY hematologists would get full value from this collection of 15 articles by 26 contributors, chiefly American.

continued page 572

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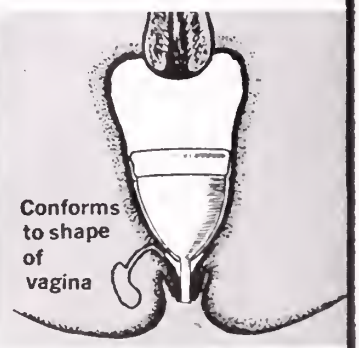
Ref.: Karnaky, K. J., Tri-State Med. J., Sept. 1961. Burrus, S. Jr., Am. J. Obst. & Gynec., Aug, 1960. Karnaky, K. J., Tri-State Med. J., June, 1960. Schaefer, G., Clin. Obst. & Gynec., June, 1959. Liswood, R., Obst. & Gynec., May, 1959.

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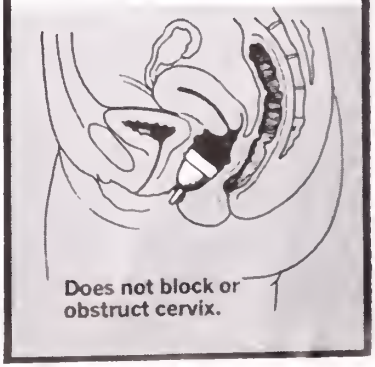
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Book Reviews *continued from 570*

Annals of the New York Academy of Sciences, Vol. 96, Art. 4

N. Rashevsky, Conference Editor, Franklin N. Furness, Editor, pp. 895-1116, The New York Academy of Sciences, March, 1962.

THIS SERIES of papers is the result of a conference on Mathematical Theories of Biological Phenomena held and supported jointly by The New York Academy of Sciences and the Committee on Mathematical Biology, The University of Chicago, Ill., May 8, 9, and 10, 1961. Fourteen contributors.

Annals of the New York Academy of Sciences, Vol. 93, Art. 5

By Aldo Castellani, Franklin N. Furness, Editor, pp. 147-206, The New York Academy of Sciences, February, 1962.

THIS ISSUE is entitled "Miscellaneous Mycological Notes."

A Study of Psychophysical Methods for Relief of Childbirth Pain

By C. Lee Buxton, M.D., 116 pp., $4.75, W. B. Saunders Company, 1962.

MOST obstetricians would want to own this.

The Surgical Clinics of North America, Vol. 42, No. 2

James Hardy, M.D., Editor, pp. 271-566, W. B. Saunders Company, April, 1962.

THIRTY-ONE contributors on "Cancer Management—Current Knowledge." ●

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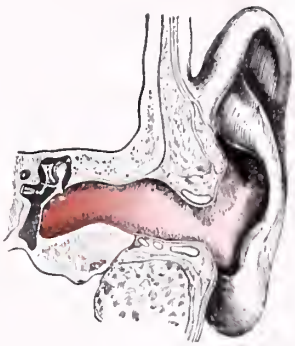
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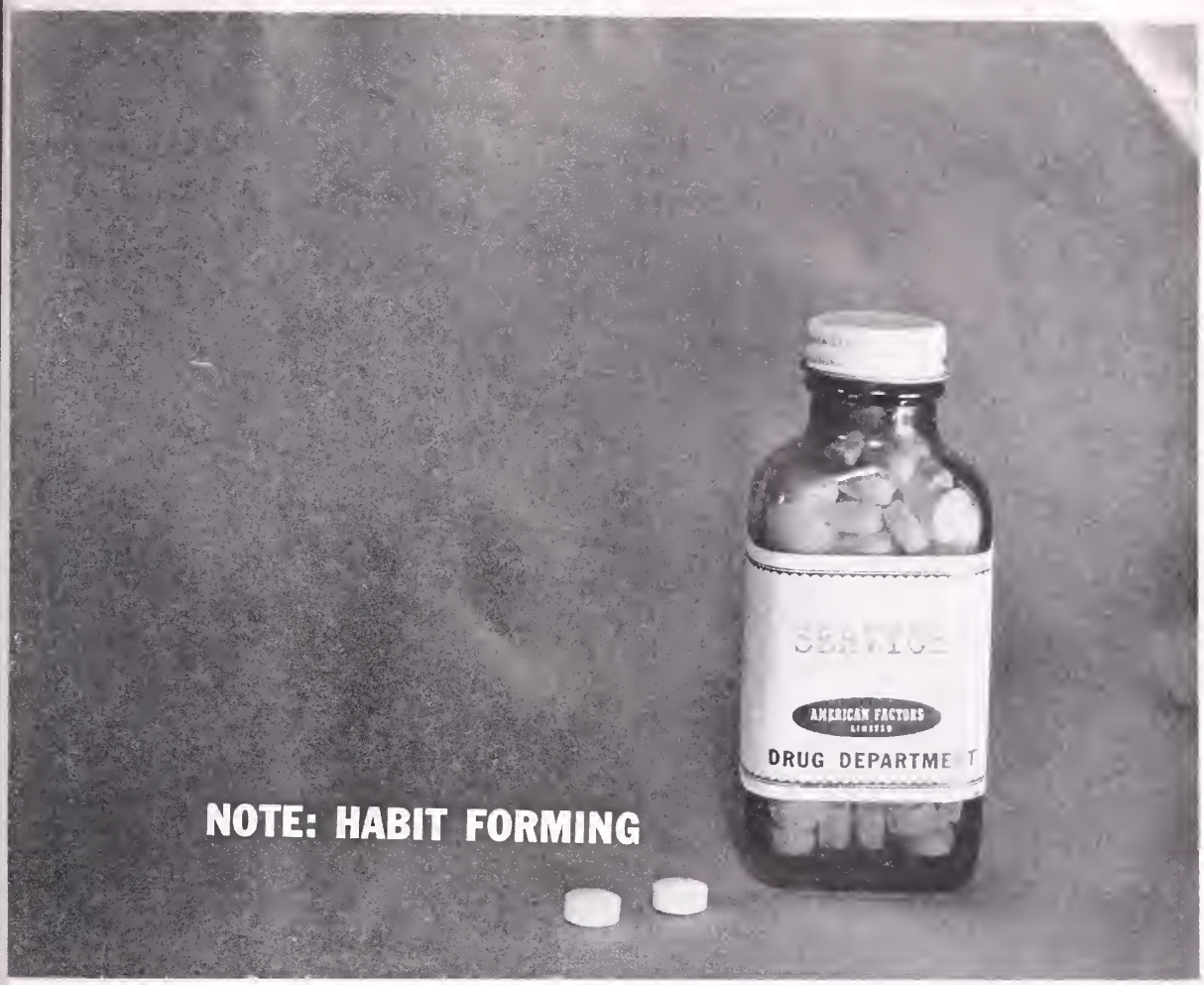
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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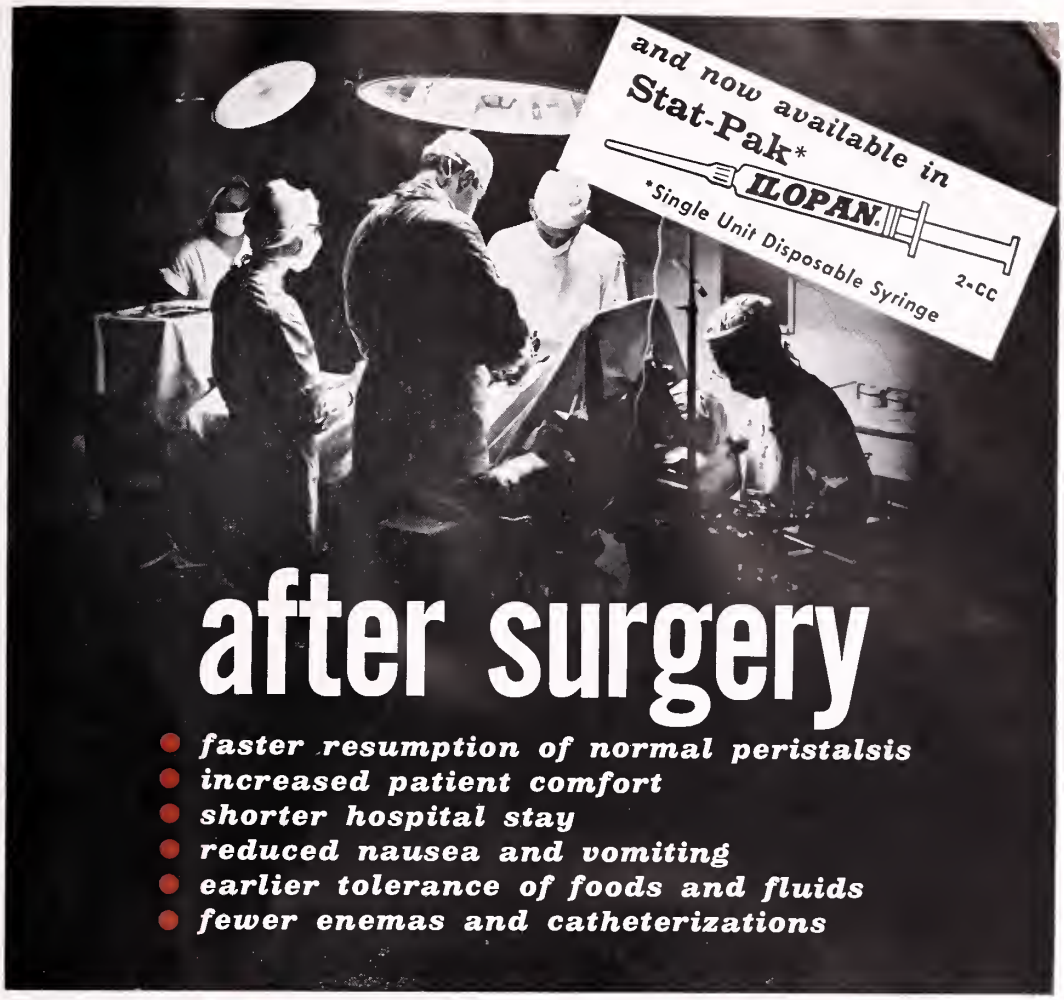
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	Page
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Ames Company	476, 579
Ayerst Laboratories	580
Baxter, Don, Inc.	569
Burroughs Wellcome & Co. (U.S.A.) Inc.	469, 478, 567, 573
Carnation Co.	473
Ciba Pharmaceuticals	565
Coca-Cola Bottling Co. of Honolulu	564
Endo Laboratories	557
Ethicon, Inc.	480, 481
Foster Equipment Co., Ltd.	558
General Electric Co., Inc.	553
Hawaii Dietetic Association	572
Hawaii Hearing Aids, Ltd.	562
Hawaii Medical Service Association	508
Hawaiian Airlines	514
Hawaiian Electric Co., Ltd.	560
Honolulu Paper Co.	479
International College of Surgeons	568
International Travel Service	566
Lederle Laboratories	548, 549, 559
Lilly, Eli, & Co.	465, 486
Lorillard P., Co.	475
Medical Industries, Ltd.	566
Medical Placement Bureau	568
O'Leary, Lydia, of Hawaii	562
Optical Dispensers of Hawaii	572
Pali Medical Building	556
Parke, Davis & Co.	466, 467
Pharmaceutical Manufacturers Assn.	576
Professional Services, Inc.	558
Robins, A. H., Co., Inc.	Insert (between 482 and 483), 483, 472, 574
Ross Laboratories	561
Royal Development Co.	560
Saunders, W. B., Co.	477
Schering Corp.	485
Schuman Carriage Co., Ltd.	564
Searle, G. D., & Co.	515
Smith, Kline & French	474
Star-Bulletin Printing Co.	556
Summers, Clinton D.	568
Tailby Nason Co., Inc.	563
Tassette, Inc.	571
Today's Health	570
Universal Motors	484
Von Hamm-Young Co., Ltd.	578
Warren-Teed Products, Ltd.	577
William Mortuary	570
Winthrop Laboratories	471

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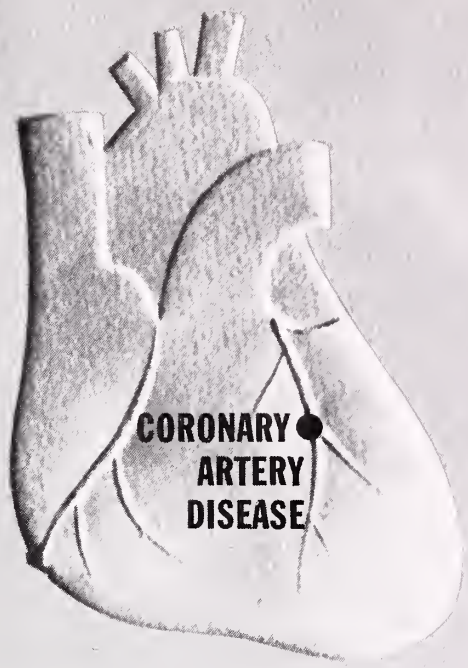
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References: (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.*, pp. 188-189. (3) Marks, H. H., *et al.*: Diabetes 9:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) 6:611-612, 1961.

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*Transatlantic Telephone Symposium, *The Effect of Estrogens in the Menopause*, Amsterdam/New York, 1959. Transcript available on request.





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